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THE NEW PSYCHIATRY

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THE NEW PSYCHIATRY

Being the Morison Lectures delivered at the Royal College of Physicians of Edinburgh in March 1915

BY

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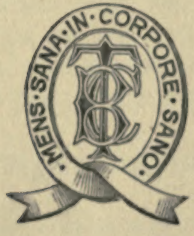

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PREFACE.

THE following lectures are a brief, almost too brief, summary of the principles and practice of psycho-analysis, and they are now published in book form at the suggestion of many friends who have not the time to wade through the very extensive literature of the subject. The almost unjustifiable brevity was in the first instance necessitated by the obligation to condense the matter within the space of three hours; but I have agreed to publish the lectures for the most part as they were delivered, as I am told that they are clear and comprehensible as they stand.

In the domain of mental disease this new psychiatry, which has not yet received sufficient recognition in this country, is one of the most important problems of the day; but it is an intrinsically difficult subject, concerning which a complete doctrine has not yet been elaborated, although an enormous amount of patient labour has been expended upon it during the last twenty years.

Psycho-analysis has, of course, met with captious criticism, the inevitable destiny of a new truth, but this has been especially severe in the case of our new psychiatry for four reasons:—

(1) The critics do not read psycho-analytic articles, or they do so only superficially, so that they arrive at quite extraordinary misconceptions.

(2) Not one of them has given the method a full and practical trial.

(3) Basing their criticisms upon sentiment and prejudice, they assume an attitude of moral indignation or haughty contempt, seeking an answer to the question, "Are these principles to my liking?" instead of the question, "Are these principles true?"

(4) The critics have been somewhat justified, in that a number of medical men, especially in Germany, practise in various sanatoria and in private what they conceive to be psycho-analysis, without having attempted to master the subject, with the result that they have done their patients more harm than

good by filling their minds with all sorts of filthy ideas, and making the most objectionable suggestions by way of therapeutic advice. I need hardly say that such charlatans, for they are neither more nor less, have through their ignorance brought discredit upon the new psychiatry which it does not deserve, for their methods, as I hope to show, are the very antithesis of those of psycho-analysis.

At the present time it would be asking too much of my readers to accept as a scientific truth doctrines which have had their birth in Austria and Germany, where truth appears to be monopolised by professors and divines for academic purposes only, and scientific discoveries are prostituted for purposes of outrage and destruction of civilisation and all that civilisation means, were it not that I can give assurances that those doctrines have been tested and accepted by earnest workers and profound thinkers in Switzerland, America and Great Britain. As a matter of fact, Freud himself has no German blood in him, but is a pure Jew. After all, Science knows no nationality and the present account is an attempt at compromise between, and combination of, the opinions of many great men.

I desire to take this opportunity of thanking Dr Ernest Jones for revising the proof-sheets and making many valuable suggestions.

I have also to thank the editors of the *Journal of Neurology and Psychiatry* for their kindness in allowing me the use of their type, as set up for publication of these lectures in that Journal.

W. H. B. S.

CAVENDISH SQUARE, LONDON, W.,
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THE NEW PSYCHIATRY.

CHAPTER I.

FUNDAMENTAL PYSCHICAL MECHANISMS.

Instinct.—In order to gain clear insight into the principles of abnormal psychology, let us by way of preliminary examine the human instincts.

Instinct is the blind prompting inherent in an animal to act without deliberation in a certain way. An instinctive action is practically perfect on the very first attempt, although there has been no previous education in its performance, and it is of such a nature as to produce certain ends without foresight of those ends. Instincts are perhaps most characteristic among the lower animals. As examples, sexual acts, migration, the first-year bird building her nest and sitting on her eggs, nutrition and care of the young, the lion stalking his prey, and the congregation of certain animals into shoals, flocks, and herds. In man one may instance the first attempt at speech by the human infant, the first attempts to walk, the avoidance of filth, making collections of all sorts of things, seeking the company of the opposite sex, nurture of the young, and the congregation into towns and cities. These are but a few examples but, even if the list were complete, it would be found possible to group all the instincts under two headings, viz.:—those subserving the function of preserving the individual and those subserving the function of perpetuating the race. They have also been classed into three categories, according as they are moved by the promptings of self-preservation, nutrition or sex.

The Herd Instinct.—Now Dr Wilfred Trotter, in two very able articles in the *Sociological Review* for 1908 and 1909, has drawn attention to the existence and importance of a fourth

instinct, gregariousness or, as he calls it, the herd instinct. Although this has long been recognised, it had never before been seriously contemplated and studied. When we come to think of it, man is much more dependent upon communal life than appears at first sight. Left to himself, he is not only extremely miserable, but his faculty of speech is useless to him and he stands little chance of survival among the other animals. Moreover, his conduct is very largely regulated by the customs of his tribe.

The advantage of gregariousness lies in the homogeneity of the herd, which enables large numbers to act in concert. In hunting and warfare, for example, the benefit of this is obvious, for the prey or enemy is more easily vanquished by a large number of hunters than by a single unit. Such homogeneity is assured by an inherent impulse of each individual to behave in the same way as his fellows and those who depart from the usual customs of the herd cease to benefit from the advantages of gregariousness, if they are not actually killed. The herd instinct, like other instincts, is maintained by natural selection.

So it happens that in company there is an unanalysable feeling of comfort, in solitude there is an unanalysable sense of restlessness and discomfort. This is just instinct. Similarly, if we depart from the customs of our particular "set" in matters of dress, amusement, religion or politics, either we feel uncomfortable or we are regarded as eccentric, and ostracised. Stage fright and shyness are the outcome of an instinctive desire to leave one's conspicuous position and to become once more one of the herd. Dr Bernard Hart recently drew my attention to a latter-day exemplification of the influence of the herd instinct in the fact that a man, who worries about the ultimate result of the war, ceases to do so when he has enlisted in Kitchener's Army. He has the unconscious feeling that he is within the fold.

Again, man is readily prepared to accept suggestions which are in accordance with the traditions of his particular herd; but he is disinclined to receive new truths which have been revealed by experience. People refused to look through Galileo's telescope, Darwin was considered a madman, the clinical thermometer was laughed at, people refuse to believe in vaccination or inoculation of any kind, new diseases are figments of the

imagination of their discoverers, and psycho-analysis is immoral, because the new must always encounter the opposition of the herd tradition. But it must also be remembered that in such instances herd tradition has to encounter opposition from the new, and may be gradually overcome until the experience becomes incorporated with the herd tradition.

In matters of opinion, however, such as politics, religion, finance, education, art, literature and all sorts of public problems, the opinions of the people ranged on *both* sides are based on herd traditions and no amount of argument will induce them to see the opposite point of view or even to adopt the only rational position in such matters, viz.:—that of suspended judgment. On the contrary they find more and more justification for the opinions they hold. In other words, belief comes first, reasons for the belief come second. This process is known as "rationalisation". It may, of course, be used in support of or in opposition to scientific truths; but even then "rationalisation" is dependent on the herd instinct for its existence.

How then are we to know whether any opinion we hold is rational or non-rational? If we find that we base the opinion on the feeling that any inquiry into the matter would be useless, barren and superfluous and that it is foolish, unpatriotic, wicked or "bad form" to think otherwise, then it must be regarded as irrational, but if our opinion is based on experience, then it is rational.

We have so far been discussing the influence of the herd instinct on intellectual processes, but we shall find that it also lies at the basis of our moral sentiments. Whenever a man does anything which he knows would meet with the disapprobation of friends he experiences a feeling of uneasiness, similar to that caused by isolation, solitude or separation from the tribe, a feeling of guilt; and when he does something which would be applauded by his fellows, he has a sense of happiness and self-satisfaction. This is, then, the basis of the moral sentiment with which the voice of conscience is indissolubly associated. A non-gregarious animal can do what it likes; it has only itself to consider.

There is a fundamental difference between this herd instinct and the personal instincts of self-preservation, nutrition and sex. These are dependent on the impulse of the moment; but the herd

instinct is a controlling force from without, which is perpetually acting in antagonism to the other three. The child is taught from the cradle to respect the feelings of its companions, to resist its own impulses in order to protect others, to comply with their desires and not to be selfish or greedy. And when the sexual passion asserts itself he finds that it is antagonised by a very strict code of conduct, with which it becomes his instinct to comply. Not only must such a passion be denied free play, but he must never allow his genitalia to be seen, and he must not discuss sexual topics or even think about them. The whole subject of sex is taboo, and this is one of the chief reasons why psychoanalysis has encountered severe antagonism. For a long time gynæcology was in the same position for a similar reason.

We find, then, that it is instinct which governs the whole of our mental life. Instinct is no more and no less than "psychical energy," the driving force of mentation to which Jung has applied the name "horme". This word "horme" has a wide signification, applicable to all the instincts, and corresponds to the "libido" in reference to the sexual instinct. "Horme" means psychical energy, desire plus a conative trend. In short, I conceive it as being more or less synonymous with instinct, the driving force of our mental life. Every individual is endowed with a certain quantity of horme. Sometimes it is active in one direction, sometimes in another; it is never quiet. Comparable to physical energy, which may display itself as movement, sound, heat, light, electricity or chemical action, it is never lost, and the principle of the conservation of energy is to be regarded as equally applicable to both psychical and physical energy. If a certain amount of horme or psychical energy in a given patient appears to be lost, it becomes our duty to discover where it has gone; but I will return to this subject later.

There is, as I have just suggested, a constant play between the instincts, one giving place to another as occasion arises; but when a herd impulse becomes displaced by the driving force of some other instinct, mental conflict ensues, there is a situation to be faced and a way out of the difficulty must be found. "'Twixt love and duty" has always been a favourite theme with artists, novelists, poets and philosophers. If duty fails, that is to say, if the herd instinct fails, some way must be found to pacify the guilty conscience.

The conflict may be resolved in one of four ways.

Firstly, the influence of the herd instinct may be recognised and its influence voluntarily ignored, the delinquent avowing to himself that he has a perfect right to do as he likes. The herd instinct is so strong that this process is, as a rule, difficult; but everybody knows that such unscrupulous persons undoubtedly exist.

Secondly, the offence may be condoned by "rationalisation", the offender excusing himself on the ground that he is otherwise a very good fellow. He goes to church regularly, subscribes to the charities, and is a good patriotic citizen, the logical fallacy here being, of course, the *ignoratio elenchi*.

Thirdly, the emotional tone or affect of worry may gradually pass off as years roll by and he becomes occupied with other matters, in just the same way as we do not feel, after the lapse of time, the loss of a dear friend to the same extent as when we first hear the news of his death.

And lastly, the incident may refuse to become assimilated to the existing content of consciousness and be forgotten. The memory is banished from consciousness, but this does not mean that it is banished from the mind. It means that an attempt is made to repress it into a department of mentation from which it can never again enter phenomenal consciousness and disturb the normal stream of associative thought. Later on we shall have to discuss what happens should this repression subsequently fail, as it frequently does.

The Unconscious.—This brings me to one of the fundamental bases of Freudian psychology, viz.:—the conception of the unconscious.

At any given moment during a stream of thought there are only one or two ideas present in phenomenal consciousness. Under certain conditions in the psychological laboratory it is possible to demonstrate that as many as six or seven ideas may be present in consciousness at the same time, but in practical thought seldom more than two ideas occupy the field of attention.

In close association with these ideas, however, at what is sometimes called the fringe of consciousness, but outside the field of attention for the moment, there is a much larger number of percepts, ideas and other mental states. These have been grouped together for practical purposes and called the "subconscious".

There still remains a large number of ideas and memories quite outside the field of attention, but capable of recall when required. These are known as the "foreconscious" or "preconscious".

Now there is an enormous number of ideas of past experiences, incidents and situations which we cannot by any possibility remember, no matter how hard we try. For these there is a life-long amnesia. Nevertheless, they are not lost. They sometimes flash into the mind in moments of abstraction and during dreams; it is said that they are all passed in review during drowning, and they can be recovered by such artifices as hypnotism, crystal-gazing and psycho-analysis. This group of ideas is called the "unconscious". The name is perhaps a little unfortunate, because "unconsciousness" has nothing to do with these phenomena, which were recognised in this country long before Freud's day and were described as "unconscious cerebration". I believe that the *name* was then the chief reason for their non-acceptance, for it was rightly contended that "unconscious cerebration" is a contradiction in terms. If hybrids were tolerated, I would suggest some such name as "hypoconscious" for such mental states. It is not pretended that every incident that has ever happened in our lives is conserved in the unconscious (although Bergson does), but it would certainly be true to say that all experiences which have been accompanied by a strong affective tone are conserved, even right back into early infancy.

Psychical Determinism. — Another fundamental doctrine of Freudian psychology is that of "psychical determinism" which postulates that every mental process is predestined and fore-ordained. According to Jung, such predestination is due to the conscious activity of a higher power, God or world-consciousness; but Freud ascribes it to an unerring scientific law of causation.

While recognising that there are certain characteristic tendencies and reactions, physical and psychical, common to all mankind, and given to us by heredity and evolution (the inherited instincts already mentioned), we must also take into account the fact that the experiences of every one of us differ from those of all other people. Instinct is the driving force which causes A and B to act in the same way when confronted with a given situation, but their thoughts and actions in association therewith are differently carried out because their individual experiences are entirely different. These, and other considerations to be discussed

presently, led Freud to the study of "individual psychology", one outcome of which has been the enunciation of the doctrine that for every psychic fact there have been efficient and logical antecedent causative mental states in the present life-history of the individual and that there is a continuity of mental associations from the cradle to the grave. In other words, there is no such thing as *chance* in the determination of a thought.

To take a favourite example. Suppose I ask you to think of a number, and you take the trouble to investigate your particular association with the number selected, you will find that the number has some relationship with an item of your experience associated with the present content of your consciousness. Under the circumstances, no other number could have occurred to your mind; the mental process concerned is absolutely governed by the laws of association of ideas.

Complexes.—The number is one unit of a constellation of ideas, another unit of which is one idea now present in your consciousness. When such a constellation is repressed and partly unconscious, it is known as a "complex".

I give a few examples to make my meaning clear.

While preparing these lectures, any patient exhibiting a good example of the mental processes I am now endeavouring to explain caused me to think of the Morison lectures, as also did mannerisms of people I met in the street, certain items of information in books, thoughts of the unconscious motives of war, and incidents of psychological interest on the battlefield, papers read to less distinguished audiences, mental facts in my own life and a host of other things. In other words, I have had a "Morison lecture" constellation of ideas. It has not been repressed and should therefore not be called a "complex".

I meet a man in the street who at one time did me a considerable injury by reason of certain jealousies &c. He is the centre of a number of ideas of difficult situations and incidents which caused me perplexity at the time, but are now repressed and partly forgotten; but I feel annoyed when I see him. This is one of my complexes.

A favourite example is that of a young man in love. His emotional state tends to constellate all his ideas to the one central figure, his lady-love, no matter how remote the association may be. The act of writing at his office desk reminds him of writing

to his adored one, a luxurious motor car makes him think how she would look in it, a chance resemblance causes him to wonder "Is it she?" The sermon at church contains many allusions to his love for her and all nature echoes his happiness. It is the "love" constellation or complex. In fact, the whole of our unconscious mind is made up of complexes, and the total mass of these taken together constitutes the "ego-complex".

A complex, then, may be defined as a repressed system of ideas having a constant conative trend or emotional tone, and directed towards determinate actions and thoughts. A complex is therefore possessed of a certain amount of energy and, since complexes can generally be referred to some instinct, we may regard this energy as a manifestation of the horme we have already discussed. The liberation of this energy by discharge, either by an outburst of emotion or by the fulfilment or realisation of the conative object of the complex, is known as "abreaction". Abreaction of the love-complex, for example, is the possession of the desired object of affection.

Conflict.—We are now in a position to consider in rather more detail the phenomenon of "conflict". When there develop in the mind two complexes which are out of harmony with one another and mutually repel or paralyse each other, conflict ensues. A hypothetical instance of conflict between two nutrition complexes is given in the fable of the animal which died of starvation when, suffering equally from hunger and thirst, it found itself midway between a basket of food and a pail of water. Conflict occurs between two self-preservation complexes when a man finds himself stranded on the high Alps, when inactivity means death from starvation and an attempt to reach the valley threatens death from precipitation. Conflict arises when a man finds he has fallen in love with two women at the same time. But conflict never arises between a nutrition complex and a sexual complex, or between a self-preservation complex and a nutrition complex unless, of course, the nutrition complex is so urgent (as in the above instance) that it constitutes at the same time a self-preservation complex. Conflict between a sexual complex and a self-preservation complex is fairly common and either may win, as in the question of plunging into a marriage which is inimical to one's life interests or facing death to save a loved one from danger.

In practical experience, however, we find that by far the greater majority of conflicts occur between a personal complex and a herd complex, that is to say, between morality, religion, ethics or fashion, on the one hand, and nutrition, self-preservation or sex on the other. Now the only ways in which nutrition complexes and self-preservation complexes can conflict with the herd instinct are by such crimes as murder, theft and dishonesty; but there is only one way in which satisfaction of the sexual instinct does not conflict with the herd instinct, viz.:—by legitimate wedlock.

Masturbation, homo-sexuality, adultery, incest, fetichism, sadism, exhibitionism and bestiality, many of which are exceedingly common, are all under the ban of the herd; and it so happens that we find, as a matter of practical experience, that by far the majority of conflicts, which we find on psycho-analysis to lie at the root of the neuroses and psychoses, are between a sexual and a herd complex.

Now a conflict cannot be allowed to persist for ever. It is a biological necessity that some way out of the difficulty must be found. The normal and logical way out of the situation is to face it, to recognise that there is a conflict, to consider what is the right and proper course to pursue and to take that course, at the same time admitting to oneself that such a conflict has existed.

If, on the other hand, the victim refuses to face the situation and attempts to evade it, this may be done, as I have already mentioned, in one of four ways.

Firstly, he may recognise the influence of the herd instinct and refuse to be guided by it. In my experience this is, as a rule, not very successful. The herd instinct is a true instinct and refuses to be repressed, with the result that the patient suffers from remorse, usually accompanied by an unexplained headache and other neurasthenic symptoms which are very difficult to dislodge.

Secondly, he may seek refuge in "rationalisation", keeping his conflicting personal complex in a "logic-tight compartment" of the mind. The swindling financier refuses to acknowledge to himself that he, as a financier, is the same individual who reads the lessons at church and built the local almshouses, or he condones his swindles with acts of piety and charity. This is

an example of what is known as "dissociation" or, as Janet calls it, the "splitting of consciousness". This phenomenon occurs quite commonly when, for example, we converse on one subject and write a letter about another, and it is quite possible for our financier, while reading the lessons, to be at the same time devising some scheme whereby he may succeed in transferring somebody else's banking account to his own.

In pathological domains we observe a similar splitting of consciousness in the general paralytic who, while believing himself to be God Almighty, begs his attendant for a cigarette, and in the asylum queen, who is elated in being the chosen patient to wait on the nurses.

Dissociation occurs also during the "automatic writing" of certain hysterical patients. If such a patient be given a pencil and a piece of paper and be held in conversation while a third person whispers questions into the patient's ear, she will correctly answer the questions by writing, all the while being unconscious of the fact that she is writing.

Another variety of dissociation occurs in the cases of "double consciousness." Here the patient has two entirely different personalities, each being independent and unaware of the existence of the other. Robert Louis Stevenson has dramatised the condition in the familiar play, "Dr Jekyll and Mr Hyde" and I need not quote the well-known case of the Rev. Ansel Bourne, reported by James and Weir-Mitchell. Gilles de la Tourette placed on record the case of a man who remembered nothing between being about his business in Paris and returning to his normal personality on board a ship bound for Bombay. Records of many similar cases are to be found distributed throughout the literature.

Thirdly, our victim of conflict may allow the energy of his complex to be diverted into other channels than the natural one. This process is called "sublimation", and the best examples are again to be found in the domain of sex.

The old maid has at one time been possessed of a sexual instinct quite as strong as that of her married sisters, but its natural outlet has been denied her. What outlets can she find for her pent-up energy? She devotes much to dress, which is often extravagant, or she indulges in all sorts of gaieties or she takes to nursing or, by a kind of transference, she interests herself in

Society news, especially of the type to be found in so-called "Society newspapers" and she loves to read the details of marriages and scandals. Moreover, her maternal complex has to be satisfied, so she reads the columns of births daily and bestows her maternal affection on cats, dogs and parrots.

A man may sublimate his sexual instincts into dangerous sports. In the early days of aviation, when it was much more dangerous than it is now, an acquaintance of mine took to this sport when the circumstances of his marriage became somewhat distressing. Sexual sublimation in men also takes the form of academic interests, increased professional activity, travel, collecting manias and alcoholic excesses. For reasons which need not be discussed for the present, Freud regards smoking as being frequently a sexual sublimation; but I am sure that it is a common sublimation of other complexes.

Sometimes sublimation takes the form of inversion or representation of the opposite. The old maid, for example, often betrays her sexual complex by extreme prudery or by devoting herself to excessive religious exercises.

Displacement of masturbation usually takes the form of the victim handling his body in other ways, such as nail-picking, nail-biting, or nose-picking; but these should not be called sublimations, because this term always means diversion to useful, social aims.

Fourthly, lastly, and most important of all, the conflicting personal complex may refuse to become assimilated to the normal content of consciousness and become forgotten. Perhaps a better way of putting this is to say that the victim refuses to admit to himself that such a complex ever existed. The popular way of expressing this is to say that he "puts it out of his mind", but what really happens is, as we shall see later, that he puts it into his mind, pushes it in deeper into the unconscious or, as we say technically, "represses" it. This is the phenomenon of "repression", really another form of "dissociation" or "splitting of consciousness". It differs, however, from the previously discussed variety in that a complex dissociated by repression has an autonomous existence. There is a constant resistance against the elements of a repressed complex becoming associated with those of phenomenal consciousness. This resistance, which is nothing more than a continuation of the original repression, is called by Freud

the "censure" and has been personified by his English and American translators into the "censor".

Now it is clear that it must be a very difficult matter for the normal train of thought to proceed year in and year out without once touching upon some idea which tends to become associated with some element of the repressed complex. Such ideas and other mental states are bound to occur and, since the "censor" will not allow repressed ideas to enter consciousness, the only possible alternative is that conscious ideas become anchored to the unconscious complex. The result is that the unconscious tends to grow at the expense of the conscious; and it may be taken as a rule that the greater the emotional tone of the original complex, the greater does that complex grow when it becomes unconscious. The fact that the unconscious grows constantly at the expense of the conscious explains why a case of long duration takes so much longer to cure than a case of recent onset.

"Dissociation" and "repression" are closely allied to one another and it will also be observed that "sublimation" usually involves "repression". The old maid's prudery is an obviously successful method of repressing her sexual complex and her fondness for domestic pets subserves the repression of her maternal complex.

It is not to be supposed that sublimation and repression are usually pathological or abnormal. On the contrary, they take place to an enormous extent in the earlier years of us all and play an important rôle in early education, whereby our naturally vicious animal energies are repressed into the unconscious and sublimated into useful activities. It follows that our unconscious consists for the most part of infantile complexes and this accounts to some extent for the amnesia which veils the first years of childhood. It is true that this amnesia is partly due to the fact that many of the cerebral neurons are not yet myelinised, but that this is not the only reason is evidenced by the fact that the amnesia is here and there broken by isolated memories of unimportant incidents. Freud has called these "cover-memories", because they serve to displace memories of important events.

When these repressions or sublimations for any reason fail, we have the conditions necessary for the development of neurosis or psychosis, conflict occurring between the repressed complex and the existing content of phenomenal consciousness. Under

such circumstances the complex escaping from repression is distorted and disguised by way of an attempt to render it acceptable to consciousness, and its distorted manifestations constitute the symptoms of the disease. Solution of the difficulty and cure of the disease are accomplished by revealing to the patient, through his own association mechanisms, the full content of the repressed complex. How this is to be done I will explain in the next chapter.

I have already mentioned that complexes related to the sexual instinct are repressed more than any other. It is, therefore, not surprising to find that these play an enormous rôle in the psychoses, and a knowledge of the development of the sexual instinct is so essential to any comprehension of the new psychiatry that I must discuss this matter in some detail. I ought to say that this knowledge has been gained, in the first instance, entirely through psycho-analysis.

The Sexual Instinct.—Those who have devoted their attention to the study of disease in children, especially nervous disease, will be the first to admit that sexuality is not a function which suddenly springs into being at puberty, but that it gradually develops from small beginnings in the earliest infancy. Freud considers that sucking the mother's breast is partly a sexual act, but Jung dissents from this view and considers the act of sucking the breast to be purely nutritive in function. Both these leaders of thought agree, however, that thumb-sucking, which follows shortly afterwards, is of undoubted sexual import, and many shrewd mothers are independently capable of discerning masturbatory significance in this common infantile action. Indeed, any action in which the child habitually handles the body, such as nose-picking, nail-biting or rubbing its abdomen, is to be regarded as betokening a masturbation complex.

Now in adult life many of the sense organs are capable of stimulating the sexual instinct; for example, the eye (in seeing a beautiful face or figure), the ear (in hearing a beautiful voice or the rustle of a dress), the nose (in sensing certain odours characteristic of the opposite sex) and the skin (in feeling the skin of a member of the opposite sex or even, with some people, experiencing a sense of pain); but the centre of maximal stimulus is the genital organ. In the child, however, there is no centre of maximal stimulation to be discovered, the pleasure-arousing area

being equally diffused all over the body and therefore so much the less stimulating in any given zone.

Freud has discovered, however, that even in the young child there are certain areas the irritation of which produces greater gratification than elsewhere. Although these lie at the foundation of the sexual instinct, it is not suggested that the child himself has any idea of the nature and significance of these sensations. These areas, which I am about to mention, have been called by Freud the "erogenous zones".

I have already referred to the mouth. Freud and others discern something of the nature of an orgasm when a satisfied baby becomes flushed, leaves the breast, and sinks into slumber. It has also been observed that thumb-suckers are liable to manipulate or rub their breasts during pleasure-sucking, and this is said to be the first step towards masturbation. Energetic suckers in infancy are said to be very fond of kissing when they reach adult life and, if at any time the complex becomes repressed, there are produced such symptoms as hysterical vomiting, aversion from eating, hysterical globus, choking sensations, snoring in the throat or disturbances in eating. These are some of the arguments used in support of the view that the mouth is an erogenous zone and some of the symptoms suggest that Freud is right in his view that breast-sucking for the purpose of nourishment is partly of sexual import. It is at least obvious that the first sensory stimulus the mouth receives is from the mother's breast and our other considerations suggest that the baby's mouth should not be stimulated more than is necessary for purposes of nutrition. This is an argument I have not previously heard against the use of "dummies" or "comforters".

Another important erogenous zone lies at the other end of the alimentary canal, the anus. It is often observed that the "intestinal catarrhs" of infancy give rise to "nervousness", but the erogenous significance of the anus is noticeable in children who voluntarily retain their fæces until violent muscular contractions necessitate expulsion. The pain caused by the passage of the larger accumulation is accompanied by a pleasurable sensation, which the child seeks to experience again. It is a variety of masturbation. This habit, which is a sure premonition of subsequent eccentricity or neurosis, plays an important part in the production of the constipation so common in neurotic patients,

and Ernest Jones has recently shown that it lies at the foundation of the sadistic complex which is responsible for the compulsion neurosis. Incidentally I may mention that a large number of such patients have private secret customs and ceremonials of their own, which they habitually observe when they retire to evacuate their bowels. People who have succeeded in repressing the complex become in after life methodical, thrifty and headstrong. It would appear that the desire to retain fæces becomes sublimated into the desire to retain money, and those who have had experience of psycho-analysis know how commonly in the neurotic "fæces" symbolises "money".

The third erogenous zone is the neck of the bladder. Freud has discovered that, whenever enuresis nocturna is not caused by epilepsy, it represents a pollution corresponding to a sexual dream. It may, of course, have its physical causes such as adhesion of the prepuce, but that does not affect the main question. It is not commonly apprehended that bed-wetting is a source of gratification to the infant. Bed-wetting in childhood plays an important rôle when neurosis develops in after life.

The fourth erogenous zone is the inner surface of the thighs. Pleasure experienced by rubbing the thighs together is often to be observed in quite young infants, especially females.

Even in the earliest years, therefore, there is a tendency for such pleasurable sensations to be localised to the neighbourhood of the genital area and Nature appears to have made special provision for their periodical excitation by uncleanliness and consequent cleansing.

The period we have been discussing is characterised by the infant finding a kind of gratification in the stimulation of parts of its own body. About the third or fourth year, however, the whole of this infantile sexuality becomes repressed by education and by the development of feelings of shame, loathing, disgust and morality. It is during this stage of repression, the "latency period" as it is called, that the infantile germs of sexuality become sublimated and applied to refining, cultural and social ends; but, should misadventure or adversity befall this sublimating process, the child is destined to become the victim of neurosis.

From the fifth or sixth year onwards, in what Jung has termed the "pre-pubertal period", we begin to observe a recrudescence of

sexuality, but it differs from the first period in that the child now strives to come into closer relationship with the outside world. The first was a period of "subject love" or autoeroticism. This is a period of "object-love" and the child seeks to love somebody other than itself. Naturally the first object of its affection is the person with whom it is brought into closest relationship, viz.:— the mother or the nurse. This is, of course, due to a feeling of dependence and is therefore very strong. Even as early as this we can discern some psychical differentiation between the sexes, for the boy's love is mostly directed towards his mother and the girl's towards her father. It is also to be noticed that a boy loves his sisters more than his brothers, and a girl loves her brothers more than her sisters. Even childish love affairs with others are of greater significance than is usually thought. It has been erroneously supposed that fixation of a boy's love on his father or of a girl's love on her mother, during this undifferentiated period, lays the foundations of inversion or homosexuality, either manifest or unconscious, but psycho-analytic experience gives no support to this view. On the contrary, it is found, curiously enough, that inversion arises from fixation on and identification with the parent of the opposite sex, as I shall explain presently.

The child's sexuality at this stage is, as Freud has termed it, "polymorphous-perverse" and untoward incidents are liable to direct his instinct into wrong channels. Encouragement of the natural tendency to undress before others may lead to exhibitionism; the habit of inspecting one another's genitals, if opportunity is allowed, may lead to the "peeping tendency" and desire to see the genitals of others, especially of their elders. Such curiosity begets an aggressive disposition, which in turn serves as a groundwork for the sadistic instinct, whose special feature is the association of cruelty with the sexual impulse. Masochism, in which the sexual impulse is aroused by certain experiences of mental or physical pain, can most often be traced to punishments inflicted during childhood.

Inversion or homosexuality arises in this way:—It is normal for the child to develop curiosity respecting sex and birth processes. Indeed, it is only natural that he should want to know where a new brother or sister comes from, for such a person threatens to displace him and to absorb the love of his mother which has previously been lavished on him. He is jealous; but

this is a digression. The normal boy imagines all people, including his mother, to be fashioned like himself in every detail. Accordingly, if the time when he is disillusioned arrives too late and incest barriers demand that his affection should be transferred elsewhere, he can only fall in love with a person fashioned like himself. Such individuals, therefore, seek as cohabitors either boys or effeminate men. Girls, who develop the converse phantasy, become homosexuals in a similar way.

As I have just hinted, the normal change which takes place at puberty is the erection of incest barriers, whereby the love for the parents becomes gradually weakened as the adolescent becomes attracted to persons of the same age, but of the opposite sex. I say "of the opposite sex", but it must be remembered that the sweetheart is of the same sex as the child's first love. Moreover, the parents usually serve as an unconscious pattern for the mates of young people. Boys have a natural inclination to some girl resembling their mother, and girls to some boy resembling their father.

There are some individuals who linger over intermediate sexual attractions so that their libido becomes permanently fixated on these, instead of passing them over rapidly on the way to an ultimate sexual goal. Such a condition is known as fetichism and the victims are fetichists. They find an ultimate sexual goal in seeing or feeling the hand, foot or hair of a woman or in hearing her voice; or their libido becomes fixated on some impersonal object such as a shoe, a handkerchief, fur, velvet &c.

When these perversities are manifest to any given person and self-avowed, they do no harm to his nervous system; indeed, many perverts have shown themselves to be of exceptional intellectual ability. Voltaire has confessed to systematic masturbation, Rousseau was an avowed masochist and it will be easy for you to recall the names of homosexuals of great ability in professional directions; but, when such perversities are repressed in an individual, he constantly runs the risk of neurosis through his repressed complex escaping the repression. If, for example, a repressed homosexual, that is to say, a person who has developed unconscious homosexual tendencies and does not know it, gets married, he is almost certain to develop neurosis or psychosis.

Now when conflict arises between a repressed complex and phenomenal consciousness; in other words, when an unconscious

complex strives for recognition, and consciousness, or perhaps I ought rather to say subconsciousness, endeavours to maintain the repression, neither one nor the other achieves success, and the result of the conflict is a compromise, this being none other than a symptom or group of symptoms of neurosis or psychosis. The discussion of the various mechanisms which come into play in this process I will postpone until the consideration of dreams in my next lecture, for the mechanism of dreams is almost exactly the same as that of the insanities. We shall find that, in its attempt to escape repression, a complex becomes distorted and disguises itself in such a way that its true nature is not revealed to consciousness.

Some of the infantile complexes to which I have referred will still remain somewhat obscure unless their nature is fully apprehended, and I must revert to the relationship between parents and children, as it is unconsciously conceived by the child. As I have already submitted, the mother is the boy's and the father is the girl's favourite parent. Now, this means a great deal more than appears at first sight, for it has been established from the study of children and from the dreams of adults that the boy's love for his mother is of such a character that he resents sharing his mother's love with anyone else, especially the father. A very large number of boys ask their mother at some time or other whether she loves him or "daddy" the more, and the child usually receives (quite rightly from an educational point of view) a disappointing answer. The boy is jealous of his father and, similarly, the girl is jealous of her mother. Each, in fact, wishes the parent of the same sex out of the way and may go so far as to dream of the death of this parent. We shall see in the next lecture that a dream is the realisation of a wish.

This incest-complex, which exists in the unconscious of every individual, normal or abnormal, is known, in the case of a man, as the Œdipus-complex and, in the case of a woman, as the Electra-complex. Œdipus was a king of Thebes who had the misfortune to slay his own father and unwittingly to marry his mother. Electra was the daughter of Agamemnon and Clytæmnestra; she assisted in the murder of her own mother to avenge the death of her father.

In a very large number of cases it can be demonstrated by

psycho-analysis that such complexes play an important part. We expect to discover it especially in patients who, in spite of normal heterosexuality and in spite of encountering many opportunities of and even calls to marriage, have reached middle age without having engaged in matrimony. This is especially to be found in *only* children, whose fixation of libido upon their parents is exceptionally difficult of transference elsewhere and whose parents tend to foster the delusion that there does not exist in the wide world a suitable mate for their darling child.

The conclusion at which we have arrived from all these considerations is that our unconscious mind is on a lower, less mental, more neural and more animal plane than our conscious mind, and it is pervaded with sexual thoughts and desires. Indeed I believe that I am not misrepresenting Freud when I say that he thinks that the unconscious mind is almost all sexual; but then it must be recognised that he uses the word "sexual" in a very wide sense. Attraction, friendliness, shame, modesty and disgust are all included under this term by Freud. Nevertheless, psycho-analysis has revealed that, if our repressed mental material had free play, uncontrolled by consciousness, every one of us "would probably remain a selfish, impulsive, aggressive, dirty, immodest, cruel, egocentric and conceited animal, inconsiderate of the needs of others and unmindful of the complicated social and ethical standards that go to make civilised society".[1] To the ordinary man, whose "herd instinct" has repressed such intolerable features of his character into the unconscious and converted him into a moral, social, ethical, modest and æsthetic being, it is incredible and absurd that his mental constitution and disposition are fundamentally so brutal. He is prepared to accept the fact that his anatomical and physiological characteristics are identical with those of the lower animals; but his mental characteristics—never! And so from time to time we find in the medical journals energetic objections to our new psychiatry, of course by people who have not studied it. These letters are interesting examples of what is technically known as the "resistance", which we shall study in our next lecture and are unwitting arguments in support of Freudian doctrines.

In the *Medical Press and Circular* for 13th June 1894 is to be found a paper by the late Dr Hughlings Jackson, entitled

[1] Ernest Jones, Brit. Med. Ass. Ann. Meeting, 1914.

"The Factors of Insanities" and it will be there seen that that great man foresaw the fundamental principles of our new psychiatry. He pointed out that there is a positive and a negative element in every case of insanity, the negative being defect of consciousness or loss of *some* consciousness, the positive being activity of the consciousness remaining (on a lower level). For example, when a patient believes himself to be the Emperor of Europe, Hughlings Jackson points out that the chief defect (negative element) of consciousness is that he does not know that he is a clerk in the city, and the notion that he is the Emperor of Europe is due to the positive activity of a lower level of mentation. This is exactly what has been proved by our modern school of psychiatry. So far as consciousness is concerned, we know that it always loses something of its content, a complex which is repressed into the unconscious, while the positive symptoms of an insanity are due to the distorted activities of the unconscious (a lower level of mentation). While, therefore, we study and admire the insight and patient labour of the great Austrian psychologist, Professor Freud of Vienna, let us at the same time pay homage to the great English father of neurology, who taught us to understand the nervous system, Dr Hughlings Jackson.

CHAPTER II.

PSYCHO-ANALYSIS.

THIS chapter is intended as a description of psycho-analysis, its aims, objects, uses and technique.

Psycho-analysis is a method of obtaining a complete history of the patient's illness and an insight into his modes of thought, such as can be obtained in no other way. A detailed history of a mental disorder includes an account, not only of the manifest disturbances of conduct, but also of the patient's thoughts in association therewith and of the various experiences and events which led up to it, together with their bearings on one another from the patient's point of view.

When all this has been ascertained, it becomes necessary to trace the patient's particular habits of thought back to their origin. Psycho-analysis achieves this result by reviving his memory for numerous incidents and events which he had forgotten, and by unearthing his hidden, repressed and therefore unconscious complexes, such as were considered in the first lecture, especially those having relationship with his present illness.

The true relationship is then discussed in such a way as to place these complexes in their true light. This is in reality a kind of re-education whereby the patient acquires self-realisation and develops his character and personality.

When all this is accomplished the recovery of the patient, which is the chief aim of psycho-analysis, results as a matter of course.

So far I have constantly referred to "the patient", but it must be understood that psycho-analysis can be practised with benefit upon a normal individual. It is, in fact, desirable and a duty for every physician who contemplates using the method either to be psycho-analysed or to psycho-analyse himself, so that he shall not read his own complexes into his patients, shall come to his work, so to speak, with clean hands, gain a knowledge of himself such as cannot be obtained in any other way and achieve that unity with himself which will give him self-confidence.

I might here mention that part of the mental equipment of

a successful psycho-analyst consists of a knowledge of ancient mythology. Psycho-analysis of the many beautiful stories of the ancients gives him a thorough knowledge of the development of human thought. A study of the symbols of the Church and of the Egyptians, Indians and Chinese, of the totemism of the North American Indians, and the superstitions of uneducated people is also helpful; for they all throw light upon the history of the development of the human mind. In each one of us our mental development is to be regarded as a recapitulation of the mental development of the human race, just as the development of the embryo is a recapitulation of the anatomical development of man.

I ought to say at once that psycho-analysis is not easy, even for those who have far greater experience of the method than I have, and it takes a very great deal of time. It is customary to spend with each patient an hour a day five or six times a week. It then takes a fortnight to obtain a complete history and a clear insight into the nature of the case, and at least three months to accomplish a cure. Most cases take longer than this, and even Freud himself, purposely selecting very difficult cases, has spent as much as three years over a single patient before he effected recovery. It is satisfactory to note that a partial analysis is often beneficial and we are constantly endeavouring to discover "short cuts", but even then we are bound to acknowledge the difficulty that psycho-analysis is expensive. It is not more so, however, than many surgical operations, and the gratitude expressed by patients is sufficient testimony that all this time and expense are well worth while.

I now come to the question "What patients are suitable for psycho-analysis?" and this resolves itself practically into "What patients are unsuitable for psycho-analysis?"

As I have already said, psycho-analysis requires intelligent co-operation of the patient. It follows, therefore, that the patient must be intelligent. He must have some pretence to education, and I do not recommend the employment of this method with the labouring classes, although successful analyses have been reported. Similarly it is not wise, at any rate for a beginner, to attempt the analysis of young children, as it requires very special tact.

It also follows that the patient must be willing to co-operate. You cannot analyse a patient who does not wish it. It is true that it is quite possible to learn much about his complexes by

conversation and critical observation, but you will be unable to reveal them satisfactorily to himself. Then there is the type of patient who proclaims that he is perfectly willing to be analysed; but, when the work has well begun, he does not take it seriously and plays his part in a desultory way. Such patients flit from one doctor to another, always dissatisfied with the last, and expect to be cured without making any effort themselves. All such patients should be left severely alone.

Lastly, it is practically useless to attempt psycho-analysis on a patient who has passed middle age. At best, the analysis of a person who has passed his fiftieth year is sure to be lengthy.

In order to render clear what classes of mental disorder are suitable for analysis, let me first explain how I classify them:—

I. *The Neuroses.*

Neurasthenia. The anxiety neurosis. Some forms of hypochondriasis.

II. *The Psychoneuroses.*

Hysteria.

The Compulsion Neuroses:—Obsessions, morbid fears and compulsions.

III. *The Psychoses.*

Maniacal-depressive insanity. Dementia præcox Paranoia.

IV. *Confusional Insanities.* (*Synaptic Rebuff.*)

Exhaustion insanities from overwork, worry and mental shock. Infection insanities, including febrile and post-febrile delirium.

Toxic insanities (alcohol, hashish, belladonna &c.).

V. *Thyroigenous Insanities.*

Myxœdema, exophthalmic goitre, cachexia strumipriva, (cretinism).

VI. *Epileptic Insanities.*

VII. *Organic Insanities.*

Cerebral thrombosis, tumour, aneurysm and abscess.
Acute and chronic meningitis.
General paralysis.
Huntington's chorea.

VIII. *Chronic Cortical Atrophy.*

Insanities of involution (abiotrophic).
Arteriopathic dementia (syphilitic, senile and renal).

IX. *Congenital Mental Defect* (*Amentia*).

Idiocy, imbecility, defective children, cretins &c.

Let us consider these in the reverse order. Cases of congenital mental defect cannot be psycho-analysed because there is insufficient intelligence for co-operation. Besides, no benefit could result from the analysis of such cases.

Patients, who are suffering from organic cerebral changes, and fall within the groups VII. and VIII., are unsuited to psycho-analysis, because the method cannot cure such diseases. It is, of course, quite possible that a patient suffering from a cerebral tumour might be benefited by the method, but it would be obviously incorrect treatment.

Of epilepsy there appear to be two varieties, one of toxic origin (probably the most common variety of idiopathic epilepsy), and the other of psychical origin. The differentiation between these can be made by inquiry into the history, when it will be found that in the toxic variety the convulsions are of more or less regular recurrence and are not traceable to any immediate exciting cause; while in the psychogenic variety the convulsions are usually induced by some mental shock or incident of psychical importance. In the former variety mental therapeutics can accomplish nothing, but much is to be expected from psycho-analysis of the psychogenic cases. Indeed, several cases of cure by this method have been reported, and it is probable that those epileptics recorded as having been cured by hypnotism were also cases of psychogenic epilepsy.

Thyroigenous insanities are, of course, best treated with appropriate medicines.

In the fourth group, mental confusion is so profound that psycho-analysis is impossible. You will observe that the alcoholic insanities fall within this group, but I must direct your attention to the fact that alcoholic intoxication and the tendency to drink excessively are two different things. The latter is to be regarded rather as a psychasthenic compulsion and would therefore fall under Class II. Alcohol is often taken as a refuge from mental conflict and, when this is the case, psycho-analysis would be the proper method of cure.

We now have the first three groups left for consideration, and these are all of interest to the medical psychologist.

Maniacal-depressive insanity is a psychosis characterised by attacks of mania and melancholia, and it may be taken as a general rule that no attempt should be made to analyse these patients during the course of one of their attacks. A maniacal patient is in too excited a condition to co-operate, and psycho-analysis during an attack of melancholia tends to make the patient worse. The analysis should be undertaken between the attacks, and many medical psychologists have come to the conclusion that it should not be pushed too far. A partial analysis of a few hours, laying bare the most obvious of the patient's repressed complexes, which are very near the surface, is often sufficient to effect a permanent recovery; whereas anything like a complete Freudian analysis only does harm. Some of the most experienced psycho-analysts, however, disagree with me on this point. I ought to say that the psycho-analyst may often obtain a hint as to the nature of these complexes by a careful study of the patient's conduct, delusions and apparently incoherent remarks during an attack; but the analysis itself should be postponed until the attack is over.

The analysis of dementia præcox should certainly not be attempted by the beginner. Most of the cases are too inaccessible mentally, while some of the earlier cases are too accessible, by which I mean that within a week of starting the analysis the patient has flooded you with an enormous tangle of repressed sexual complexes, out of which there seems to be no possibility of escape. The most favourable cases are those of katatonia. I must warn the beginner against cases of dementia paranoides for his own sake. Negative transference, which I shall be explaining later, is liable to be set up, and may induce the patient to inflict actual bodily injury upon his doctor, which may go as far as

murder, a most undesirable sequel to the doctor's patient efforts.

The same state of affairs may arise in the analysis of cases of paranoia, but we also encounter another difficulty. The patient suffers from a systematised delusional state on which he bases his whole attitude to the outside world, and he refuses to believe that there is anything amiss with his mentation. This being the case, it is only to be expected that he will refuse mental treatment of all kinds. I have not myself had the opportunity of attempting psycho-analysis of a patient of this kind, but some of my colleagues have told me that they have been successful with some cases. I understand, however, that most psycho-analysts regard the prognosis of this disease as unfavourably as it was deemed before the introduction of their method of treatment.

In Class II. we come to the cases for which psycho-analytic treatment is pre-eminently satisfactory. These are the cases upon which Freud made his earlier and, indeed, the greater part of his studies. These are the cases that the psycho-analyst likes to meet.

Many hysterical patients can be cured by other means, and there is no necessity for psycho-analysis until such means have failed or unless persistent relapse occurs after the treatment.

For the compulsion neurosis, however, imperative ideas, obsessions, morbid fears, irrepressible thoughts and morbid impulses, there is no other treatment than psycho-analysis, which is remarkably efficient and satisfactory.

Of course, no psycho-analyst claims that his method is infallible, even in cases of hysteria and psychasthenia. It is necessary to say this because many of the critics like to say that he does put forward such claims. Psycho-analysis has its failures as well as its successes, just like any other mode of treatment; but we do claim that psycho-analysis is more successful than other methods in suitable cases, the reason being that each patient is treated as an individual with a mind of his own, peculiar to himself, and not as a person suffering from a disease for which the panacea is a "rest-cure", now well-known to be inefficient in many cases.

The disorders of Class I. are also suitable for psycho-analysis, but it is soon found that a complete psycho-analysis is unnecessary, because the cause of the trouble is soon found and appropriate advice can be given accordingly. I shall refer to such matters in the next chapter.

Technique.—Before beginning a course of psycho-analysis it is necessary to make sure that it can be continued. You must be sure that neither your own engagements nor those of the patient are likely to interrupt it. To leave the patient with a half-revealed complex for more than a day or two will only make him worse. For this reason psycho-analysis is ill adapted to institution work. At any rate, it cannot be carried out by medical officers whose time is occupied by administrative duties. In private, the financial aspect must also be considered and you must be satisfied that the patient can afford to continue the treatment for at least four months, not only because a doctor cannot afford to spend an hour a day without remuneration, but because free cases are for some reason unsatisfactory to treat.

The patient is first systematically examined, and a provisional diagnosis made. All defects in physical health are remedied, such as errors of refraction, carious teeth, sources of septic infection, nasal obstructions, and so forth.

When it has been decided that the patient is a suitable case for psycho-analysis, he is directed to sit in a comfortable arm-chair by the consulting-room table, more or less facing the doctor. This is my own method, but some physicians arrange that the patient shall face another way, so as not to be distracted by his examiner's changes of expression. Freud himself recommends that the patient lie on a comfortable couch and that the physician sit at the head of it, so that the patient cannot see his face.

Many physicians begin with an association experiment with, or more usually without, the use of a galvanometer, sphygmograph, and stethograph. If it is decided to employ these instruments, the sphygmograph and stethograph are fitted with a Marey's tambour and revolving drum for recording alterations in the frequency of the pulse and respiration. The galvanometer, if used, should be delicate, astatic and of high resistance, and it should be arranged with its two poles lying in two basins of water. The circuit is completed through the patient, each of his hands lying in one of the basins of water. A galvanic cell generating a weak electrical current may or may not be introduced into the circuit. In an association experiment with an ordinary patient, all these instruments are mere accessories, but they may play an important part in attempting the analysis of a suspected criminal.

The physician now takes a list of quite ordinary words, usually

about a hundred, and reads them one by one to the patient. These are known as "stimulus words", and the patient is required to react to each in succession by stating the first word that comes to his mind in association with the stimulus word. The physician works with a stop-watch and the patient is required to react as quickly as possible; a normal reaction takes about two seconds. Opposite each stimulus word the psycho-analyst writes the "reaction word" and the time taken by the reaction.

I append here a list of suitable words, but it is as well for the doctor to introduce here and there words which appear to have some bearing upon the patient's own malady.

Quiet	Law	Correct	To play	Despise
Wall	Trouble	Pencil	Threaten	Tooth
Journey	Whisky	Woods	Habit	Book
Bible	Justice	Yellow	Dance	Wild
Apple	Work	Dream	Afraid	Box
Salt	Lion	Insolent	Child	Thirsty
Tobacco	Hammer	Ride	Sing	Hard
Cottage	Crowd	Soldier	Frog	Moon
Love	Paint	Thief	Proud	Glass
Sorrow	Rent	Green	Wool	Sympathy
Sheep	Ring	Joy	Doctor	Street
Water	To listen	Quarrel	Brother	Harm
False	Kiss	Choose	Men	To tell
Wash	Policeman	Deep	Health	Boy
Rich	Soft	Mouth	Mountain	Table
Dark	Stork	Anxiety	Rough	Duty
Window	Luck	Friend	Bed	Ink
Wish	Foot	Smooth	Girl	Carpet
Dog	Change	Dirty	Blood	Knee

These words are read through a second time and the associations again noted, but it is not necessary to record the reaction time on repetition.

The doctor now searches his results for what are known as "complex indicators." These are:—

(1) Undue prolongation of the reaction time (four seconds or more).
(2) Failure to react to a word.
(3) Strange and incoherent associations.
(4) Apparent contradictions.
(5) Perturbation of several reactions following a certain association.
(6) Failure to react with the same word on repetition of the test.

(7) Accompanying motor and vasomotor phenomena, such as restlessness, lip-biting, nail-picking, blushing, &c.
(8) Increase of frequency of the pulse and respiration.
(9) The generation of weak electrical currents by the body, or, if a cell is introduced into the circuit, alteration of the electrical resistance of the body.

By a little detective work it is often possible to make a shrewd guess at some of the patient's repressed complexes; but your own conclusions should never be communicated to the patient. It is legitimate to ask him a question which forces him to admit something that he is obviously withholding, but it is not permissible to do more than this.

The various "complex indicators" just mentioned are due to intra-psychic "resistances". Some of these are between the preconscious and the conscious, and constitute resistance to a disclosure of the complex *to you*. Others are between the unconscious and the preconscious, and constitute a resistance to disclosing an unconscious complex to the patient's own consciousness, and incidentally to you.

These "resistances" have to be overcome, and the method is to take each of the associations which have revealed themselves as complex indicators, and get the patient to explain them. This he can very readily do with many of his associations by relating some incident in his past experience. Some will prove valueless and be discarded, others worth noting.

Some of his associations, however, will turn out to be a puzzle to himself. These are important and should be followed up. What is called "continuous association" may first be tried, the patient being told not to stop at the first association, but to go on from one word to another until some light is thrown on the first association; or the particular reaction may be used as a starting point for a "free association" to be described presently. If during a series of continuous associations the patient comes to a stop, a block, a resistance, he should be urged to find an association. You say to him, for example, "Go on, you must think of something!" then, after a short pause, especially when he shows some motor restlessness, "What is in your mind now? You must tell me". In this way you work through all the reactions and, by the end of the test, you have a very fair amount of material to work upon.

The method of "free association" is conducted in much the same way, except that no stimulus words are given. The patient is directed to make himself quite comfortable and to assume a passive, inert frame of mind. He is then told to allow his thoughts to flow as they will and to exercise no control of them whatever. As they flow in this way he is to speak everything that comes to his mind; no matter how incoherent his speech may seem, or how painful or repugnant the thought may be, he must speak it out. He is to allow his thoughts and speech to run wild. In this way his associations will here and there tap the unconscious. After a few sittings you can sometimes tap the unconscious almost as soon as he enters the consulting room by making some utterance which calls for no specific reply, such as "Yes?" or "Well?" and waiting for him to speak. It may seem ungracious or unceremonious that you should not enter into the conversation, but you must let him do all the talking.

In the course of a free association you will again come across "resistances". The patient will tell you that his mind is a blank and that he can think of nothing. You reply, "Never mind: go on talking". Or he will become silent. Your reply is to become silent too. You wait for seven or eight minutes sometimes, looking at him expectantly the whole time, until something comes up from the unconscious; or you interrupt the silence suddenly with "Talk! what is the matter with you? Go on talking!" or, at the slightest sign of restlessness, you say, "What are you thinking of now? Why don't you tell me?"

These resistances are difficult to describe because they vary so much with different patients. I have seen a patient fall over the side of the chair, as if collapsed, remarking, "Oh, doctor! what are you doing to me?"—a patient, mind you, who went about his business during the rest of the day as if there were nothing the matter with him, although he was constantly tormented by psychomotor hallucinations and other symptoms.

From time to time it is well to recapitulate to the patient what he has told you and get him to draw his own conclusions as to the nature and cause of his malady. I wish to insist a little on this point, that he tells you and that you do not tell him, because the critics like to say that the psycho-analyst puts suggestions into the patient's mind. It is true that the patient will sometimes ask, "Is that right, doctor?" to which my usual

reply is, "Of course it is right, because it is your mind that has come to this conclusion, not mine, and the malady is yours, not mine." Sometimes, of course, it is necessary to counteract some absurd conclusion, but I have found that such conclusions usually originate in a suggestion given to the patient by another person. Beginners in psycho-analysis are liable to make this very mistake. They tell the patient their conclusions as to the nature of his complexes before he has discovered them for himself. These are what Freud has termed the "Wild psycho-analysts". Sometimes their conclusions are correct, sometimes incorrect. One patient of mine told me that a certain doctor after one week's analysis informed him that he was in love with his mother, to which, not understanding what was meant, he replied, "Of course I'm in love with my mother". Now it happens that the doctor was right; the patient's libido was unconsciously fixated on his mother, so much so that, although he was forty years of age and had been in love many times, he could never bring himself to marry the girl of his choice. Psycho-analysis, as a method of bringing hidden complexes to light, has been compared to opening an abscess; but this doctor's method was more like hitting an abscess, not opening it.

I can here foresee an objection that there is no need for the psychologist if he be not allowed to supply interpretations of the patient's data or even to engage in conversation, and I have indeed had the experience of a patient who, while admitting her recovery, remarked "But I do not see what you have done". I accepted that as a very great compliment.

As a matter of fact, the work of the psychologist is at times very great in overcoming resistances, which sometimes last for several sittings. One form of resistance for which you must be on the watch is what the Germans call *vorbeireden*—as we should say, "talking past the point." The patient suddenly becomes loquacious and hurries past a certain association, just as a hostess at a dinner-party may suddenly become talkative and change the conversation, knowing that it is getting dangerously near a tender subject for one of her guests. The analyst's duty is the reverse of this. He brings his patient back to the point, discusses it right out and perhaps starts a new series of associations. Then again it is desirable to encourage associations which promise to revive infantile memories. Such memories are usually strongly visual

and difficult to associate with words; it is therefore well on such occasions to ask the patient to close his eyes, to see pictures, and to relate what he sees. Indeed it is helpful in all psycho-analysis that the patient should keep his eyes closed. His mental and bodily attitude should resemble that of going to sleep in that the mind should be allowed to wander, but there is the difference that the subject's attention is directed to his own psychical activities. Of course he requires a certain amount of practice before he is able to do this successfully.

His part of the work is by no means easy and many a patient attains peace of mind at the expense of his hair turning grey; not as a result of the difficulty of technique, but as a result of overcoming resistances.

I now come to the interpretation of dreams which Freud has designated the "royal road" to the unconscious. In sleep, those parts of the nervous system which subserve phenomenal consciousness are more or less in abeyance and they are only aroused temporarily by associative stimulation from the nervous mechanisms subserving unconscious activities. If these unconscious activities were allowed to become conscious, if they were allowed to rouse the nervous arrangements subserving consciousness to full activity, sleep would of necessity cease: but the constant desire of the sleeper to go on sleeping prevents unconscious activities from becoming conscious in an undisguised form, so that sleep continues under the guardianship of the dream. This will become clearer as I proceed.

The interpretation of dreams, being the royal road to the unconscious, constitutes a very important part of psycho-analysis.

We have to recognise the "manifest" and the "latent" content of a dream. The manifest content is contained in a description of the incidents of the dream as the dreamer would relate them at the breakfast table the following morning; but, by studying the mental associations of dreams, Freud has discovered that each contains a deeper meaning, which has been called the latent content. This latent content is invariably the imagined fulfilment of an unconscious wish. This is the real purpose of dreaming, to gratify unconscious desires which can obtain gratification in no other way; while it is the distortion of the dream which serves as the guardianship of sleep.

In children and imbeciles, who are children who have not mentally grown up, the wish-fulfilment is undisguised. If a child dreams that it has a rocking-horse, or that it is driving its father's motor car, this means that he would like a rocking-horse or he would like to drive the car. In a child very little repression has yet taken place and therefore unconscious mentation plays a very small rôle in the mind of the child. In an adult, on the other hand, the wish-fulfilment is disguised and distorted so as to be unrecognisable by the phenomenal consciousness of the dreamer. I shall not have time to discuss fully the psychology of this distortion, but I may say that roughly it is necessitated by the censorship existing between the unconscious and the preconscious. The disguise is assumed so that the dream material may pass the censor into consciousness.

Before discussing the mechanism of this distortion, let me say that the material upon which a dream is based consists of:—

(1) Some incident of psychical importance on the day before the dream—the dream-day—or at least some memory, occurring during the dream-day, of some recent incident of psychical importance.

(2) Some memory of long ago, usually early childhood.

(3) The fulfilment of an unconscious wish. This may be incited by a wish during the dream-day which circumstances prevented being gratified, or by a wish unfulfilled and suppressed during the dream-day, or by some wish arising from the unconscious during the night, or by an actual wish-incitement occurring during sleep, such as thirst or distension of the seminal vesicles. Freud considers, however, that a wish occurring during the dream-day is insufficient to provoke a dream unless it is reinforced by an infantile wish.

It may be taken as a general rule that all the dreams occurring in the same night refer to the same subject, and most people have had the experience of a series of dreams occurring on successive nights, obviously relating to the same subject. In such a series the wish fulfilment is more boldly expressed and less concealed in the latter dreams than in the earlier. It is therefore wise to start the analysis of such a series by taking the last dream first.

That the dream actually has a secret meaning which turns out to be a wish fulfilled must be proved afresh for every case by means of an analysis; but it is helpful to know what are the

mechanisms of distortion, although dreamers themselves will tell you this to a certain extent as the analysis proceeds.

The mechanisms of distortion are exactly the same as those which produce symptoms of the psychoses and psychoneuroses, viz.: Displacement, Condensation, Symbolisation and Dramatisation. These and some other features of dreams I will briefly explain.

1. *Displacement.*—The unimportant details of a dream are often the most significant, as also are the parts which are vague, subsequently forgotten (repressed), or are related differently on being told a second time ("secondary elaboration" to which I shall refer again). It is best to start analysing a dream at such parts. Similarly when a person has a "dream within a dream", when he dreams that he wakes up from a dream and goes on dreaming, saying to himself "Why, I was only dreaming", such "dream within a dream" is important. By this I mean that disguise is regarded by the censor as incomplete and that analysis should therefore be so much less difficult.

2. *Condensation.*—Almost every element of a dream represents not one, but a number of unconscious thoughts fused into one conscious thought, so that the element is said to be "over-determined". For example, Freud relates that a lady dreamed that she had crushed a June bug ("ladybird", as we would call it) in shutting down a window. This incident in the dream condensed the following thoughts: She had allowed a moth to drown in a glass of water; she had read a story the evening before of some boys throwing a cat into boiling water; she was occupied with the subject of cruelty to animals; years before her daughter used to be cruel to insects by pulling off their wings; she also used to collect butterflies, and used arsenic to kill them; during the same year there was a pest of ladybirds and the children used to crush them, at the same time she saw a person tear off their wings and eat them, and so on.

Ernest Jones tells of a patient who dreamed that he met a man named Lysanias, who is mentioned in Luke iii. 1 as being the tetrach of Abilene. Analysis revealed that the patient had indulged in *licen*tious sexual practices when at the *Lyc*eum (as they called his school) in an old *abbey* with a boy named Leney. This is, of course, a remarkable instance, but such condensation is not an exception, but the rule. Persons, for example, who are

unknown to the dreamer are regularly composite persons constructed from several people he does know. Sometimes such condensation is accomplished by the presentation of the features of one person with the mannerisms and speech of another. Condensation causes vividness of the presentation and, *vice versâ*, vividness implies condensation.

3. This is a convenient place to mention that dreams are always egotistic, and that the dreamer himself is always represented. Indeed he is always the chief actor, and a person in the dream whose features he cannot recognise may be himself. If there is difficulty in deciding which of two unknown persons represents the dreamer, it is a safe rule to assume that it is that one whose emotional experience is the greater. This brings me to another subject.

4. *Emotional Affect in Dreams.*—The emotional tone attaching to any percept in a dream is never distorted. It is always correct. It is true that the affective tone may not appear, but when it does, it is always the correct one for the situation. The situation, however, is disguised; so that pleasure may be felt when the dreamer meets three lions in the desert, the lions symbolising three friends, or fear may be expressed when the dreamer has the chain of mayoralty placed around his neck, if the chain symbolises the hangman's rope. This brings me to the subject of

5. *Symbolisation*, which is rife in Dreams.—In the majority of cases, symbols are a cloak for some sexual idea. Long objects, such as sticks, umbrellas, ships and airships, snakes and trees, commonly represent the penis. A patient of mine dreamed that he was climbing a marble pillar; on analysis it turned out that the pillar represented the penis and that climbing it symbolised masturbation. Caskets, boxes, wagons and such articles usually indicate the female body. Tunnels and passages represent the vagina. Rhythmical movements, such as sawing, filing, horse-riding and going upstairs, are symbolic of the sexual act. Emperor and empress and king and queen are the dreamer's father and mother. Right and left often mean right and wrong in a moral sense. Architectural symbolism is quite commonly employed for the architecture of the body; and the associations belonging to plant life and to cooking are often chosen to conceal sexual images.

6. In this connection I may refer to "somatic displacement".

The nose or an arm may symbolise the penis, and the head may symbolise the uterus. A patient of mine dreamed that she had an intense headache which was relieved by her emitting masses of red flesh from her mouth. Analysis revealed that the dream was the disguised fulfilment of a wish to have another child, the headache symbolising labour pains and the masses of flesh representing the baby. She suffered from the anxiety neurosis and her husband had practised coitus interruptus since the birth of her first and only child seven years previously, when she experienced great suffering from the difficult labour.

7. Inversion or representation of the opposite is common. As examples, another person's attempt to kill you may represent an unconscious wish on your part to get rid of him. A tree carried on a man's back may be symbolic of his penis. The sequence of events may also be transposed. I ought here to contradict in part what I have said about the emotions in dreams, viz., that they are always correct if applied to the latent content. It happens occasionally that an emotion is represented in a dream by its opposite. Inversion of some particular element usually means that something else in the dream is also inverted.

8. The doctor himself, the psycho-analyst, is often represented in the dreams of patients. In a particularly transparent dream a patient of mine found herself in church. There was a large congregation including a certain clergyman—the Rev. X.—while another clergyman whom I will call Y. was conducting the service. The Rev. Y. and the whole congregation then vanished or left the church with the exception of the Rev. X. and my patient. On analysis the Rev. Y. turned out to be myself, and when I tell you that a crowd or multitude of people signifies a secret, the interpretation becomes clear. The patient had a secret which she did not wish to reveal to me, but wished to do so to the Rev. X. There was no congregation, *i.e.*, no secret, when I had gone.

9. *Dramatisation.*—Incidents, people and things are selected and arranged so as to present the dream in a more or less dramatic form. Both past and future become the present so as to fit into the picture.

Conjunctions such as "if", "although", "as though", "either-or", and "because", do not occur in dreams. Logical relationship is represented by simultaneity, "because" by succession in time, and "either-or" is equivalent to "and" in the dream.

10. *Secondary Elaboration.*—Dreams are not commonly related with the strictest accuracy, even when the sleeper wakes, and they are frequently changed here and there on being related a second time. In waking moments the censor is more alert, and the latent content becomes still further disguised in order to render it acceptable to clear consciousness and just in those parts where there is an unconscious feeling that the disguise is not sufficiently complete. These, therefore, are favourable points for starting the analysis of a dream.

A dream is usually analysed easily if there has been much resistance to relating it, or when there are such remarks as "But it was only a dream!" or "What is the use of telling it? That will not help me". Attention should always be paid to such comments on the dream and they should be regarded as part of the latent content.

In analysing a dream, it should be taken item by item. The patient should be asked who or what is represented by the item. He should be directed to form a series of associations with it and told to speak everything that comes to his mind, as has been described as free association. Often it is useful to start again from the beginning, when it is usually found that the associations lead by another path to the same conclusion, except where there is condensation.

The associations of various items are then reviewed and the patient is asked to state his conclusions as to the meaning of the dream. The doctor then assigns it to its particular complex for future use.

Of course an experienced psycho-analyst can often see the meaning of a dream more readily than the patient, but he should always offer any interpretation tentatively, saying, for example, "Of course, you will be able to tell me whether the interpretation I am about to suggest is correct or not. If I am wrong, please say so." If the interpretation is right, the patient will often acquiesce quite readily. If incorrect, his reply is something like, "Oh, no! I am sure it does not mean that". If the interpretation is only partial or if it is partly right and partly wrong, he will say, "It might be" or "I don't think so", indicating some uncertainty. It quite frequently happens, however, that a correct interpretation induces the strongest denial and resistance to insight; but his protestation is too much and the very stout-

ness of his disclaimer betrays the fact that the interpretation is correct. It is better, however, to leave a dream unexplained than to force your own construction on the patient.

Again, in psycho-analysis generally, it may be desirable, after recapitulating the data already obtained, to explain your own interpretation of the patient's symptoms. For example, symptoms occasionally arise as a result of repressed homosexuality, the patient having no idea what homosexuality is, or even knowing that it exists. In such a case it would be necessary to explain this to the patient.

I will conclude my remarks about dreams by quoting a foot-note from Freud: "In general it is doubtful in the interpretation of every element of the dream whether it

(*a*) is to be regarded as having a negative or positive sense (relation of opposition);
(*b*) is to be interpreted historically (as a reminiscence);
(*c*) is symbolic; or whether
(*d*) its valuation is to be based upon the sound of its verbal association.

"In spite of this manifold signification, it may be said that the representation of dream activity does not impose upon the translator any greater difficulties than the ancient writers of hieroglyphics imposed upon their readers."

Dreams are so important and helpful in psycho-analysis that I have taken them as a pattern of the various clues and hints of what is going on in the unconscious; but we can often obtain many suggestions from apparently trifling incidents and habits occurring in the patient's everyday life.

I have already mentioned the "press of conversation" or *vorbeireden* occurring during an analysis as a complex indicator. Similarly, the patient may assume a sudden laughter or merriment during the serious work, an obvious attempt to disguise a painful thought. He may abruptly start picking his nails, or a woman may toy with her hair or write figures with her finger on her lap. Twitches of the mouth and eyes and many such trifles, all of which I have seen in patients, all mean something and the meaning has to be elicited by analysis.

I have referred in Chapter I. to such "symbolic actions" as

the old maid keeping many pets or interesting herself in the newspaper reports of divorce scandals.

A common experience of psycho-analysts is that patients leave some of their belongings after a satisfactory interview. This is an unconscious way of expressing a wish to return for further treatment.

People who have displayed a tendency during childhood to pilfer or lie and still have an unconscious tendency in the same direction are scrupulously careful to pay for everything "on the nail", as the saying is, or to be excessively precise and truthful whenever they make a statement, thus giving a hint of their repressed complex.

Ask any nurse why she took up the nursing profession and she will give all sorts of reasons why she was justified in considering herself a born nurse; but, if you will take the trouble to investigate her history, you will find in quite the majority of cases that there has been some unhappiness in her domestic circle or that a younger sister has found a husband. They would not admit such reasons, even to themselves, and I make no complaint against their work.

A spendthrift usually has all the apparatus for saving money—cash-box, ledger, day-book and the rest of it, but his unconscious tendency prevents him from using them.

These are generalities, but patients and others often supply particular examples of the work of the unconscious. Dr Bernard Hart quotes a patient, for example, who had an irresistible impulse to examine the number of every bank note which came into her hands. Analysis revealed that this habit dated from an occasion when she asked a man, with whom she was in love, to change a coin for her. He complied with her wish and, putting the coin in his pocket, said that he would not part with it. This remark raised her hopes that her love was reciprocated, and any money passing through her hands always reminded her of the incident. The man passed out of her life, however, and she strove to banish the episode from her memory and to forget that such a desire ever crossed her mind. The repression was successful and the complex was thenceforward only allowed to enter consciousness in disguise, viz.:—as an interest in money, which became crystallised into her exaggerated preoccupation with the numbers of bank notes.

An illustration from Jung. An old female patient of an asylum spent all her time huddled up and performing a stereotyped action resembling that of a cobbler sewing boots. Investigation showed that she had, as a young girl, been engaged to a shoemaker, and that the engagement was suddenly broken off.

Freud has demonstrated that the forgetting of proper names, far from being fortuitous, is always due to the activity of the intra-psychic censor. Whenever a name is forgotten or incorrectly remembered a reason can always be discovered, usually by a quite superficial analysis, why it has been forgotten. Some disagreeable memory is the common cause, associated either with the individual or with a person or place of the same or a similar sounding name. In other words, the forgetting is neither more nor less than a repression. Examples of this occur in everybody's experience every day. I always have a difficulty in remembering the name of a certain town in Italy, Ferrara, where—owing to a piece of foolishness—I had to run for nearly a mile in record time in order to catch a train in which I had already placed my luggage. The forgetting of resolutions belongs to the same category of unconscious phenomena, the commonest example being that we are more liable to forget having borrowed money than having lent it, although none of us would admit to ourselves that we have dishonest propensities.

The mislaying of objects gives another series of clues to the unconscious. I have already mentioned that patients are liable to leave some of their belongings, usually an umbrella, in the halls or waiting-rooms of psycho-analysts. Bills are more apt to be mislaid than cheques. If a cheque is mislaid, you will find that you have a feeling that you have not given sufficient value for the money or that you have failed to declare it to the income-tax authorities or that you do not like the person who gave it to you or there is some other unpleasant association with the cheque.

Mistakes in speaking, reading and writing (*lapsūs linguæ et calami*) belong to the same category. They are betrayals of repressed complexes and no psycho-analyst allows such a mistake made by himself to pass without searching for the hidden cause of it.

A psycho-analyst always gets his patients to relate to him such symbolic actions, failures of memory and lapses of the tongue and

pen, so that he may investigate them and thus gain access to the unconscious tendencies of his patients.

I must here refer to another psychological mechanism which often serves as an indicator of repressed complexes, not only in nervous disorder, but also in every-day life. I refer to "projection".

The peculiarity of this phenomenon is that the effects of the repressed complex are attributed by the individual possessing it, not to himself, but to some other person. A few examples will explain my meaning. People who are guilty of some failing, imperfection or weakness, of which they are ashamed, are exceedingly liable to attribute the same fault to others. If a thief loses an article, his first thought is that somebody has stolen it from him, and the man who is ever ready to disbelieve any statement made to him is himself a person who is habitually economical of the truth. The dishonest financier is always on the alert lest somebody should swindle him and he is exceedingly intolerant of anybody who succeeds in doing so. The man who is unfaithful to his wife is usually suspicious that she may have been unfaithful to him, and how often have we all heard an asylum patient declare that his wife is insane, or a drunkard accuse his consort of insobriety. Self-reproach is so unpleasant to consciousness that it is repressed and converted into reproach of other people.

The mechanism of projection is common in many forms of insanity. I remember a patient who travelled all over England in search of an imaginary lady, whom he supposed to be in love with him, the real truth being that he himself had an unconscious desire to get married; and some unmarried ladies at the climacteric have their libido unconsciously fixated on some unfortunate individual, with the result that they think that he has fallen in love with them or is paying them undesired attention.

Hallucinations sometimes arise in this way. The patient, instead of accusing himself of some fault, refuses to acknowledge to himself that he possesses it, and believes that other people are accusing him, the hallucinations being in reality symbolised self-reproaches.

Perhaps I ought to mention two other methods of tapping the unconscious, which do not, however, belong to psycho-analysis proper.

Crystal-gazing is one.—It does not require much practice and is quite easy for a neurotic patient. He is directed to abstract his mind from all normal sensory impressions and to gaze intently

into a glass sphere. A black background is preferable and it is advisable not to have too much illumination. Clouds appear in the ball at first, which advance and retire synchronously with respiration. Then the many reflections are unconsciously combined to form an illusory picture, which is at first vague and indistinct, but the unconscious soon fills in the details. Definite hallucinations then form which ultimately take on movement. These hallucinations represent some forgotten incident of the past life of the individual, with much less distortion than takes place in dreams. The percipient, being detached from surrounding impressions and awake only to those of his sub-conscious self is probably in a mild state of hypnosis.

The patient relates to the doctor all that he sees in the crystal ball and, the memory of some incident having been revived, he is urged to connect it with his present content of consciousness by the association methods already described.

The method is not much used, but I have sometimes found it helpful in overcoming resistances in the interpretation of dreams.

Hypnosis is the last method which I shall mention of penetrating the field of the unconscious. It is explained to the patient that he is to be hypnotised and the object of the procedure is expounded to him. He is directed to offer no resistance, but to allow his mind and body to become perfectly supple and flaccid, and he is told that failure to hypnotise him will be due to resistance on his part, all hypnosis being in fact auto-hypnotism. One of the various methods in common use is then employed.

On account of unconscious resistance, however, it is quite unusual, except in cases of hysteria, to obtain deep hypnosis in a neuropathic patient. Should the hypnotism be so successful as to abolish his normal consciousness, his unconscious mind is laid bare and it becomes possible to discuss with him details of incidents which in the waking state are completely forgotten. Such a state would be ideal for the recovery of repressed complexes if it could be easily induced; but it was this very difficulty that caused Freud to give it up in favour of his method of free association.

It is a matter of experience that persons who have been partly psycho-analysed are very easily, but not deeply, hypnotised; but people who have been completely psycho-analysed right back into their earliest years of infancy cannot be hypnotised at all, presumably because they have no unconscious.

If a person is to be psycho-analysed I prefer that he should not be hypnotised. For some reason or other, previous hypnosis appears to increase resistance, to augment the power of the censure. Patients who have undergone a course of hypnotism are in my experience unsatisfactory to treat by psycho-analysis. Hypnotism should, as a rule, be used for post-hypnotic suggestion only.

The Transference.—In the first lecture I explained that every constellation of ideas which we call a "complex" is possessed of a certain amount of psychical energy or horme, desire plus a conative trend; and it is this horme or libido which usually conflicts with the herd instinct and brings about that mental conflict which secures adjustment by repression of the whole complex into the unconscious.

Fixation of the libido in the unconscious may be on the father (Œdipus-complex) or on the mother (Electra-complex), on a person of the same sex as the patient (homosexual-complex), on a person of the opposite sex who has passed out of the patient's life or even on an inanimate object (money, for example). When, therefore, by the methods I have described, an unconscious complex becomes conscious, this libido becomes conscious too, but this time its object is not available. The method of psycho-analysis has itself divorced the libido from its former object. There is therefore a certain amount of libido, synonymously psychical energy, floating free, so to speak. What becomes of it? Such a state of affairs cannot possibly persist. It becomes attached to or fixated on the personality of the physician. This is a stage which must be attained by every patient and is known as "the transference". To some extent a similar feeling of dependence and confidence occurs in every patient, whether he be suffering from heart disease, phthisis, cancer or any other organic disease; but it is enormously exaggerated in a neuropath who is undergoing treatment.

All psycho-analysis proceeds *vid* transference. Psycho-analysis means using transference for the purposes of treatment, it being the only way in which buried memories can be recovered. It is often difficult to see how on earth certain infantile fixated relationships can possibly be transferred to the physician, but the patient's unconscious mind discovers a way, usually with the help of a dream. When, as commonly happens, the infantile fixation is of a hostile nature, the patient's unconscious mind is most insulting to the physician, although superficially he is as polite as

ever. Under such conditions, when the transference has been effected, it may be very disagreeable and indeed dangerous. In patients suffering from delusions of persecution for example, the patient then regards the physician as his persecutor. Jung of Zurich told me of a patient of his, who presented him on recovery with a loaded pistol which, during the stage of transference, was intended to be levelled at him. This is known as "negative transference". It must never be forgotten that during the transference the neurosis is as active as ever. There is a recrudescence of many of the symptoms of the former neurosis with the difference that some earlier person is replaced by the person of the physician. A similar transference on the part of the physician has to be guarded against ("reversed transference" it is called) and is to be avoided by self-analysis.

It is the commonest complaint of neurotic patients that they are not understood, but in the psycho-analyst they have found a man who listens sympathetically, tries to understand them and never gets annoyed by their constantly recurring resistances. The doctor has become a kind of father confessor who has penetrated the secrets of his soul far deeper than any father confessor ever does, while the patient has found a prop against which he may lean for evermore. He considers the situation ideal and resists all attempts to alter it, even reverting to all his former phantasies in their new relationship.

This is the state in which the father confessor would leave him, but the psycho-analyst must place the patient upon his own feet. In other words, the next stage in the treatment is dissolution of the transference relation. This is the most difficult part of psycho-analysis, because the resistances are stronger than ever. It is to be accomplished in exactly the same way in which the transference relation was produced, viz., by psycho-analysis.

In this, dream interpretation will again play an important part, for it will now prove a useful guide in our search for the future object of the libido. We must find new interests for the patient and encourage him in them, so that he may come once more into practical relationship with the world around him. During this process all his symptoms crumble away and, in the end, he finds himself neither better nor worse than other members of the community around him, but just a normal person.

CHAPTER III.

APPLICATIONS AND RESULTS.

In this Chapter various matters are discussed which have been elucidated by psycho-analytic methods respecting the neuroses, psychoneuroses and psychoses.

Freud recognises two neuroses proper, viz.: Neurasthenia and the Anxiety Neurosis. Probably a few cases of hypochondriasis are due to the same etiological factors as these neuroses and should therefore be included in the same group.

Neurasthenia is a term which hitherto has been used very loosely and the separation of the Anxiety Neurosis as a distinct disease is due to the clinical insight of Freud. The term "Neurasthenia" is now limited to a class of case which exhibits very definite symptoms, the chief of which is an undue tendency to fatigue. This is well demonstrated in ergographic tracings from neurasthenic patients. In a normal person such tracing shows a gradual increase of power at the beginning of the experiment, so that the lever rises more and more with each successive contraction. This is ascribed to the effect of practice. Subsequent contractions remain at the same level before fatigue sets in, when the level rises less and less until, the finger becoming absolutely useless, the tracing becomes a straight line. With a neurasthenic, on the other hand, the initial increase of power due to the effect of practice is not shown. The first few contractions may be of an average height, but fatigue sets in immediately and the contractions become weaker and weaker.

The same phenomenon is shown in experiments devised for the purpose of investigating the laws of mental fatigue. In Weygandt's method, for instance, the patient is given a sheet of paper with columns of figures to be added. He starts at the first column and, at the end of a minute writes down his result so far as he has gone. Then he passes to the next column, adds for a minute and puts down the result as before, and so on through the whole series. In a normal person, at first the effect of practice is noticeable in that the added portions of the column get longer and longer until, fatigue setting in, they grow

shorter and shorter. In the neurasthenic, on the other hand, the added portions shorten from the very first. Mistakes in the addition also occur earlier than in a normal individual.

The so-called "irritable eye" exemplifies the muscular fatigue, the patient complaining that the eyes ache on reading for a short time, although no error of refraction can be found. Examination with the perimeter soon fatigues the retina and, unless carried out quickly, the visual field will be found contracted or spiral.

These patients are anxious enough to be busy about their affairs like other people; but all effort, mental or physical, leads to an intense feeling of fatigue. In many cases, even the thought of doing anything causes the patient to tremble and to break into a profuse perspiration. Other symptoms are a sense of pressure on the top of the head, often localised to one spot on the left of the middle line, and various paræsthesias, especially of the joints and muscles and the back of the head over the occipital spine. The last is explained as a "crawling" or "screwy" sensation, and was aptly described by one patient, whose case was related to me, as a feeling as if there were a black-beetle inside the skull lying on its back and kicking to get on its legs again. Feelings of abdominal discomfort also occur and there may be hypochondriacal notions respecting the genito-urinary apparatus.

Similar symptoms frequently occur in states of general debility, such as chlorosis, and in the early stages of organic nervous disease, such as disseminated sclerosis or general paralysis. In these conditions the case should, of course, not be labelled "Neurasthenia"; but when the above symptom-complex occurs independently of any other disease, then we have to deal with a case of true neurasthenia.

Now, in all cases of this kind, without exception, there is always to be found one essential etiological factor, viz.: sexual excess. In the majority of cases this takes the form of masturbation, but in a few patients the disease is traceable to frequent nocturnal pollutions and I have come across a still smaller number of neurasthenics who, being habitual *roués*, owe their neurosis to excessive indulgence in normal sexual intercourse. These last cases differ in recovering easily and rapidly as soon as the cause of their malady is explained and removed. Freud and many of his followers, however, believe that neurasthenia has essentially an *auto-erotic* etiology.

The pathogenic influence of masturbation is easily comprehensible when we consider the severity of the mental conflict which must occur in association with every act, and it has been suggested that the outflow of energy is excessive because it corresponds to the amount discharged by *both* partners to a normal sexual act.

Suitable advice and recommendations as to mental hygiene are the proper remedy; but it is often necessary to carry out a certain amount of psycho-analysis in order to trace and uproot the complexes which constitute the foundation of such irregular sexual impulses.

The "Anxiety Neurosis" is characterised, as its name implies, by a persistent state of anxiety or fear, usually without obvious cause, but sometimes initiated by some real cause for anxiety. This state is always out of proportion to its cause and the other symptoms of the neurosis are exaggerations of the normal physical signs of fear. Such are irregularity and an increased frequency of the pulse, palpitation, anginal attacks, general vasomotor constriction with coldness and blueness of the extremities, dryness of the mouth, perspiration (especially of the hands), polyuria, diarrhœa, respiratory oppression and air hunger, even attacks of asthma, vertigo, tremor, attacks of ravenous appetite, nausea and sometimes actual vomiting, night terrors and insomnia, hyperæsthesia for visual impressions and especially for noises, and a general apprehensiveness.

Such patients are liable to exacerbations of their various symptoms, in which the sense of terror may be extremely severe, with a feeling of congestion in the head and a dread of impending death. It is even said that there may be temporary loss of consciousness, but I have not seen such a case.

It may seem extraordinary that a disease with such a wealth of symptoms should not have been recognised before, but it is simply due to the fact that these cases have hitherto been labelled "Neurasthenia", a term which possessed the vaguest significance, while the physician remained puzzled.

It is to Freud that we owe the recognition of this disease, and it was Freud who discovered the essential etiological factor. He and all who have subsequently investigated the matter are agreed that the anxiety neurosis owes its origin to an accumulation of mental excitement which finds no somatic outlet, and further

that this excitement is almost always, probably always, of a sexual nature. Accordingly we meet with this neurosis among engaged couples who cannot afford to get married, in widows and widowers, in women whose husbands practise coitus interruptus (this is the commonest cause), in women during the climacteric whose husbands have reached senility, in patients who with great effort have renounced masturbation, and such persons. Some authorities regard the mental factor as more important than the somatic and explain the anxiety neurosis as the result of sexual excitation under circumstances in which the mental constituent (desire) is not allowed to reach consciousness. Ernest Jones, for example, says, "The desire is diverted from consciousness and becomes converted into its opposite—namely, dread; morbid dread is sexual desire that the subject does not wish to feel."

While sexual abstinence in its many forms is the chief cause of the anxiety neurosis, it is not pretended that there are not important contributory factors. Heredity is one, and the condition also arises from overwork and exhaustion, especially after severe illness and prolonged watching by the bedside of a sick relative by night as well as by day.

Unfortunately, the obvious remedy for such a neurosis is often impracticable and it is my custom, in these cases, to seek by means of a short analysis interests of the patient into which his repressed energy may be directed (sublimation of the sexual impulse) and, in the meantime, to prescribe some anaphrodisiac medicine, my favourite mixture for such purposes being a combination of the monobromate of camphor with the extract of black willow.

The psychoneuroses and psychoses are on an entirely different plane from the neuroses. The neuroses, as we have seen, owe their origin to existing causes, probably of a chemical nature, at the time of the malady, but the psychoneuroses and psychoses are compromise formations between repressed wishes and the forces which repress them; that is to say, that their mechanism is exactly the same as that of dreams. The obvious differences between dreams and the psychoneuroses are that, in the one, the subject is asleep and desires to go on sleeping while, in the other, he is awake; and also that dreams are normal while psychoneuroses are abnormal. Yet even these differences are not absolute; for, on the one hand, certain neurotic symptoms, such as

somnambulism, night terrors and nocturnal paralyses, are definitely associated with sleep and, on the other hand, we have to bear in mind the day-dreams of certain hysterical patients. Again, certain anxiety dreams occur in neurotic patients only.

The similarity is therefore closer than appears at first sight, and in both we have exactly the same mechanisms of distortion—the frequent importance of minor symptoms, condensation, transference of the affect, symbolism, somatic displacement, ellipses, inversion and dramatisation.

One might see a difference in the fact that, in the psychoneuroses and psychoses, the patient actually lives his dream; yet even here we must be cautious, for I have known two or three patients whose first symptom was a dream which was believed on waking and has since remained in the respective patients' minds as a memory of an incident which actually occurred.

Perhaps I may be allowed for purposes of elucidation to take a purely imaginary case of a pretty young girl who, in a household of three persons, acts as the servant and drudge of her two older stepsisters and is not allowed to appear as a member of the family lest some eligible young man's attentions should be diverted from one of the older sisters to the youngest. Her natural wish is that she should escape such slavery and happily marry some handsome young man of wealth and position; but such a wish has to be brushed aside as impracticable and it is repressed into the unconscious. If she reads the fairy tale of Cinderella, being a normal person, she thinks how delightful such happenings would be if they occurred to her, but she puts the thought aside with the book and resumes her drudgery.

At night her wish escapes repression in a dream in which she herself is Cinderella and, as the midnight hour strikes, she awakes to find that it was all a dream.

If, however, she is a psychotic person, she may first develop ideas of persecution by her elder sisters and, after passing through a morose period, develop hallucinations of vision and hearing and, living in a world of her own, believe that she is really Cinderella and marries the prince. Ultimately she becomes an asylum queen. Her wish is fulfilled and she is a case of dementia praecox.

If, instead of this, our patient develops a condition of motor excitement with boastfulness and loquacity, playing all the while

with the idea that she is destined to become a princess, but always holding to her relationship with the outside world, she is then a case of acute mania, with every probability of recovery, but subsequently always running the risk of a repetition of such an attack should her environment, or even perhaps a chance remark by association, bring her repressed wish within the realm of consciousness.

Now let us conceive the relationship between our paradigms to be that of half-sister instead of stepsister and, being children of the same parent and brought up together, let us suppose that at one time our Cinderella had a certain amount of affection for her half-sisters and that at some period of her life there may have been a conflict between love and hatred of them. Her love has been repressed and now her whole affective tone is one of hatred. She has even played with the notion that some fatal accident might occur to them and that she might thus be released from her unfortunate position. She will not admit to herself that such an idea has ever crossed her mind, and it becomes in turn repressed. In course of time the repression fails and the unconscious wish reappears in consciousness in a distorted form—let us suppose in an inverted form, so that she suffers from a constant fear that some fatal accident may happen to her. She is the victim of a hysterical phobia and would be classed as a psychasthenic.

On the other hand, her former love for her sisters may have had such a permanent influence on her mind that her affection is for ever afterwards unconsciously directed towards people of the same sex as they are, the same sex as herself. In other words she is a repressed homosexual. Her unconscious reasoning then runs thus: "I do not like men"; this by projection becomes "Men do not like me", "Men hate me", "I am persecuted by men". She is then a paranoiac.

Lastly, if her mental conflict is not between her repressed wish and repressing forces, but between the repressed wish and an inhibition, she becomes a case of hysteria. Her unconscious wish is to go forth and seek her predestined lover; the inhibition is that she must busy herself about the house and do menial work. A compromise is sought between the two and she develops, for example, a hysterical paraplegia which excuses her both from her work *and* from carrying out her unconscious desire.

I now consider these various disorders in slight detail. The

essential characteristic of any hysterical manifestation, as I have just suggested, is that it is a compromise formation between a repressed wish and an inhibition. I desire to lay stress on this as an important point.

There are two varieties of hysteria—anxiety hysteria and conversion hysteria. The former comprises hysterical phobias, hysterical day-dreams and what one may call hysterical attacks; the last includes cases in which the repressed complexes are converted into somatic symptoms.

Phobias or morbid fears may occur in many forms of mental disorder. Hitherto there has been a tendency to refer them all to the obsessional or compulsion psychoneurosis, but psycho-analysis has revealed that they frequently take their origin in a conflict between a repression and an inhibition. As this is one of the characteristic features of a hysterical symptom, we must therefore recognise the existence of a hysterical phobia.

Hysterical day-dreams or hypnoid states are interesting in that they closely resemble ordinary dreams. Brill gives several excellent examples, which I will quote, and he agrees with Freud in stating that they invariably occur in patients who have renounced masturbation and refuse to relieve an over-stimulated sexual impulse.

Three stages of these dreams are to be noted, the first being one of euphoria with fantastic exaltation, the content of which deals with the individual's aspirations, the second a dream-like withdrawal from reality in which the patient is no longer controlled by logical reason and judgment, and the third is an absent-minded depressive stage. These three stages correspond with and replace those of masturbation: (1) fantastic euphoria, (2) self-absorption and gratification, and (3) depression.

A young woman used to imagine herself married to a handsome, wealthy man. She had three most beautiful children. They all lived in blissful happiness on a magnificent yacht and entertained most charming people. Then the whole structure crumbled; her husband and children died and she was left alone in a terrible depression lasting for days.

A young weaver, who thought he was persecuted by his employer, used to think what he would do if he had £400 a year. He imagined himself starting a shop and earning much money by oppressing his employées. The business grew until he had

hundreds of people working for him. He became greater and greater until he found he had lost all his money on the Stock Exchange.

A young journalist imagined himself running a race and winning, when he was struck in the thigh by the spiked shoe of one of the competitors. He is bleeding and his trainers try to stop him, but he strikes them aside and runs on, winning the race. Then he collapses exhausted and is carried off amidst the cheers of the crowd.

A case from Freud. A lady fancied herself in delicate relationship with a piano virtuoso whom she did not know personally. In her fancy she bore him a child. He deserted her, leaving her and her child in misery. She then suddenly found herself in tears in the street along which she happened to be walking.

Those who are familiar with psycho-analysis will discern the sexual complexes underlying these day-dreams:—the desire for marriage in the first and last, the sadistic complex in the second, and the exhibition tendency in the third.

I have said that these hysterical day-dreams are said to occur in patients who have renounced masturbation, but we must go deeper than this to explain the content of the dream, and this leads me to the essence of Freud's theory of hysteria.

I ought to say that I have come across cases of hysterical day-dreaming in which masturbation certainly played no part. Only recently I had a lady under my observation, who imagined that she knew a soldier, named Paul Graham, in the Royal Field Artillery in the trenches. He would come home on leave and she would meet him at Brighton. On analysis, Paul was identified with a character in a novel she had read, and Graham suggested Graham White. This was one of many day-dreams she had had in her life, but masturbation certainly played no part in this case. On the other hand, she had been subjected to many sexual assaults between the ages of six and fifteen.

Freud's theory of hysteria depends on the recognition of the infantile development of sexuality. Many incidents of sexual import occur during childhood which at the time have no sexual significance, but the recollection of them after maturity is disproportionately exciting because puberty has in the meantime incomparably increased the reacting capacity of the sexual

apparatus. More than twenty years ago Breuer thought that these occurrences were of the nature of gross sexual assaults on the child, but ever since that time Freud has recognised that they are in reality nothing more than commonplace events whose importance is exaggerated by the patient after puberty. I mention this especially because some authors are still keeping up the idea of the infantile psychic trauma which all responsible authorities have abandoned for many years. Ordinary infantile ideas tend to fade with time, but sexual infantile memories are accentuated during normal biological development and are reinforced at puberty and during later life in a way in which no other experiences are strengthened; but inasmuch as they can then find no appropriate sexual outlet or reaction, they are repressed into the unconscious and, if particularly strong, form an abiding focus of mental irritation.

These unconscious infantile memories influence the whole sexual life of the individual and in the cases we have just considered are the determining cause of the masturbation. When the repression fails we find that fantasies have been weaved round the original experience and they reappear as such hysterical day-dreams as I have just related.

These hypnoid states, as they have been called, are subconscious rather than unconscious manifestations of hysteria. Sometimes, however, the fantasies or memories assume an unconscious form and then we have the so-called hysterical attacks. These consist of a series of emotional displays which are rendered comprehensible when the physician has discovered the underlying thought, for he is then able to see that such emotional manifestations are such as might be expected to occur in response to the given stimulus. They are indeed, as a rule, grossly exaggerated; but they occur independently of any idea in the patient's true consciousness of the situation to which he is reacting. The affective state is entirely dissociated from the situation which gives rise to it. In common with the dream—the hysterical attack represents the fulfilment of an unconscious wish. Attitudes are assumed which look as if the patient is trying to avert some danger or he (more commonly she) assumes lascivious postures which leaves no doubt in the mind of the onlooker that some sexual idea underlies the clinical picture. Those who have any doubt on this point might with advantage

look at the beautiful illustrations in Richet's book on hysteria, which were produced long before the sexual etiology was seriously proclaimed.

Lastly, we have "conversion hysteria" which results from a persistent strife between some painful memory and the restraint of the censor from its coming to the surface, the result of the struggle being a compromise whereby the idea by distortion becomes converted into a somatic symptom, some bodily motor or sensory innervation or inhibition.

Freud relates the interesting case of a patient who consulted him for an intractable facial neuralgia. By psycho-analysis this was traced to an occasion when she was insulted by her husband. The insult was forgotten but subsequently appeared in symbolic form as "a slap in the face". The same patient suffered from globus hystericus which symbolised "I have to swallow that".

In some cases astasia-abasia is symbolic of dependence and helplessness, inability to make headway, having no support, and so forth.

Somatic displacement occurs. Jung mentions a case of a hysterical patient in whom a stiff arm symbolised an erect penis, and one of Brill's patients suffered from a hysterically painful breast which was directly traceable to an occasion when, during an embrace, she felt the pressure against her thigh.

The common symptom, hysterical vomiting, is frequently traceable to some sexual basis. In one case it signified disgust or self-reproach, because the patient has perceived a genital sensation on the occasion of a kiss.

It will have been gathered that psycho-analysis is to be regarded as the most radical form of treatment of hysteria and other functional mental disorders to be presently discussed, but I might refer also to other methods in common use. Weir-Mitchell's "rest-cure" is quite fashionable at the present time and undoubtedly gives good results in many cases, provided it be used rationally and in combination with some psychical influence at the same time. Suggestion is most commonly used and Weir-Mitchell's private opinion of the whole procedure was that it acted mainly as a suggestive agency. The prolonged mental and physical rest are beneficial, the removal from home surroundings has the advantage of withdrawing the patient from

an environment which has usually proved somewhat irritating, the massage and possibly the electricity tend to improve metabolism, and the over-feeding is well suited to patients who are ill-nourished. Let me say at once, however, that this method is worse than useless in any other condition than hysteria and, even in this disease, failures are far from uncommon. Moreover, the expense is often as great as for psycho-analysis.

Hypnotism may often be employed with advantageous and often dramatically successful results in hysteria. Hypnosis is much more easily achieved in this disease than in other mental disorder and it may be used in one of three ways:—

(1) To get the patient into an extremely suggestible mood so that suggestion of recovery may be given.

(2) To recover buried memories.

(3) To get the patient to react emotionally to such buried memories or, as Freud would put it, to obtain an abreaction to a repressed complex.

The compulsion neurosis is a disease which shows itself in a large number of ways. The patients have clear intellect and good memory and they are well orientated in time and place, but they suffer from mental symptoms into whose morbidity they have clear insight. They suffer from irrepressible thoughts which often take the form of metaphysical questionings, such as "When was the beginning of all things?" "What existed before that?" "Who created God?" or they attach undue importance to superstitions or they cannot help repeating in their minds things they have heard.

Many suffer from morbid fears, fear of open spaces, of closed doors, of heights, of vermin, of broken glass, of pins, knives and so forth. Others are in fear of blushing under certain circumstances, with the inevitable result that they do blush, or they are afraid that their bowels will act at an inopportune moment, as in church, at a concert or in the train, again with the not unusual result that their fears become justified.

Then there are the morbid, irresistible impulses in which the patient feels impelled to perform certain acts against his will. As examples, arithmomania or the impulse to count things, to count one's steps, the rails of a fence, the rungs of a ladder, the windows of a house, &c.; the impulse to read every advertisement or placard one comes across or even another person's newspaper or

letters, the impulse to steal (kleptomania), the impulse to set things on fire (pyromania), or to commit homicidal and suicidal acts.

Some authorities regard certain motor agitations, such as the tics, as obsessions. This may be right in the early stages of a tic, but it would be wrong to do so when the tic ceases to be consciously performed.

Some of these patients have feelings of *incompleteness* in action, in intellectual problems, in emotional reaction and in perception. Others have strange feelings of unreality and of depersonalisation, called by Janet psycholeptic crises.

The unity of this disease has been recognised for many years in spite of its multifarious symptoms. Fifty years ago it was called "volitional insanity", on the hypothesis that the essential basis was a weakness of will-power. Then it was called "obsessional insanity", a term which was justifiable in that it offered no explanation. The mind is obsessed or besieged by such thoughts, fears or impulses.

Janet advanced a step by recognising what he called a "splitting of consciousness" or "mental dissociation" induced by a "lowering of the psychological tension", the psychical response of a psychasthenic to his environment being inadequate.

Freud regards the compulsion neurosis as a disease of the unconscious. From his laborious investigations on individual psychology by means of psycho-analysis he interprets the condition on a purely sexual basis and regards the symptoms as substitutions for certain repressed sexual ideas and emotions. They are due to failure of the repression, whereby the sexual ideas are enabled to find conscious expression in symptom formation. Moreover, two characteristics of these patients have emerged. One is a special aggressiveness during childhood, which mainly shows itself in an intensive activity of the impulse to learn about sexual matters and the mystery of birth by looking, gazing and peeping on the one hand and by aggressive questioning on the other; the other is an incessant conflict between love and hatred, a continual existence of these two emotions in the highest intensity side by side toward the same person. An intensive elaboration of the feelings of affection and hostility towards the parents, brothers and sisters, in conjunction with infantile sexual curiosity regarding sex and birth processes, forms the essential nuclear complex of this psychoneurosis.

Love and hate cannot, of course, exist together indefinitely and the conflict is ultimately resolved by one or the other, usually the hatred, being repressed into the unconscious.

The symptoms of this psychoneurosis then take their origin from a conflict between conscious attachment and unconscious sadism. The sexual experiences of the early childhood of these patients are pleasurably accomplished aggressions and pleasurably experienced participation in sexual acts. In this psychoneurosis, therefore, the repressed complex is one of sexual activity, whereas the repressed complex in hysteria is one of sexual passivity.

It is true that by psycho-analysis of such patients one is ultimately able to disclose some infantile sexual experience in which the patient played a passive rôle and which awakened his interest in sexual matters. This in turn is followed by actions of sexual aggression. This period is brought to an end by the appearance of sexual maturity, often self-ripened. Reproaches then attach themselves to the sexual memories and they are repressed and replaced by primary symptoms of defence. The patient is apparently normal and healthy, but in reality he is in a state of successful defence, the only symptoms being scrupulousness, shame and diffidence.

The next period is failure of the defence with return to consciousness of the repressed reminiscences and revival of the reproaches, but always in a changed form, the change being necessary in order to escape the watchfulness of the censor. There is a compromise formation between the repressed and the repressing ideas, this compromise formation becoming conscious as an obsession or an obsessive effect.

The form which the disease assumes depends upon whether it is the memory of the reproachful acts themselves which forces itself upon consciousness or the memory of the reproach affect, the emotion of self-reproach. In the first case the feeling tone is merely one of discomfort; if the memory of the reproachful acts had not been distorted, the feeling tone would of course be one of reproach. In the second case, the reproach affect is changed into some other unpleasant emotional feeling, such as shame, hypochondriacal, social or religious anxiety, fear of being observed or tempted, and so forth. You will easily see that this symbolisation of the reproach affect renders diagnosis very difficult.

Besides these compromise symptoms there are others which

Freud groups together under the name of "secondary defence". These are protective measures against the obsessions, actions which, if performed at the time of the reproachful action, would have prevented it from occurring. Many patients perform ceremonials which are apparently meaningless until the forgotten action against which they are directed is known.

The patient has no conscious knowledge of the action against which his obsessive acts are directed, and he explains them to himself in some transcendental or abstract thought—(1) an actual occurrence is put in place of a past experience and (2) something sexual is replaced by something analogous, but non-sexual.

Dr Ernest Jones, who is the greatest English authority on the psychology of the neuroses, has recently discovered that the origin of the repressed hatred in the compulsion neurosis is traceable to anal eroticism in infancy. Compulsory education of the sphincters in opposition to anal erotic tendencies, such as were described in the first lecture, is responsible for the patient's conflict with the outer world. The anal eroticism is, of course, repressed in very early infancy; but the hatred, usually of one or other parent, remains for a considerable time. Our conclusion, therefore, with regard to the psychoneurosis is that an obsession represents a compensation or substitute for an unbearable sexual idea of *very early infancy*, and takes its place in consciousness, whereas a hysterical symptom is the realisation of an unconscious fancy serving as a wish-fulfilment and corresponds to the return of a sexual gratification which was real in *later infancy*, but has been repressed since then; the *obsession* being due to a conflict between a repressed idea and the repressing forces, and the *hysterical symptom* to a conflict between the repressed idea and an inhibition.

Psycho-analysis has proved the only really successful method of treating the compulsion neurosis, but hypnotism may be used in much the same way as for hysteria, viz.: (1) for suggestion, (2) to recover buried memories and (3) to obtain an emotional reaction to a repressed complex.

Some cases of obsession may be traced in the first instance to some forgotten incident to which the patient did not react at the time; with the result that there appears to be a certain amount of latent emotion, floating about free, as it were, and unattached. It then becomes attached to other subjects, people,

situations and ideas, so as to give them some unusual and unintelligible significance to the patient. The mechanism is known as "transvaluation."

For example, a patient came across some broken glass in some mashed potato she was eating. The occasion was forgotten, but reappeared years later in the disguise of a fear lest poisons in glass bottles should escape and become attached to her person. On account of this, she would never pass a chemist's shop on the same side of the road. Such a patient might have been hypnotised and made to live over again the unfortunate meal, this time reacting with an emotion of terror, so that such emotion should not in future become attached to glass bottles. As a fact, she was psycho-analysed and deeper sources of the psychoneurosis were discovered.

Dubois' method of treatment by appeal to the patient's reason may be dismissed as grotesque and possessing no novelty, for has not every young asylum medical officer tried to argue with patients that there is no ground for their morbid fears or delusions and has he not invariably learned that such a method is futile?

"Resynthesis" and "transmutation" are more rational. For both of these it is necessary that the physician should first devote a considerable amount of time to obtaining a complete history of the patient's life, the ultimate object of the first method (resynthesis) being to direct the patient's attention to other points of view than he at present takes, and that of the second method (transmutation) being to divert his interests and energies into new channels, these being selected in sympathy with his natural trends. The latter treatment is known in America as "side-tracking" and is really an attempt at what I have already described as "sublimation". Both resynthesis and transmutation have been characterised as methods of re-education. In resynthesis some workers, especially of the French school, employ such artificial aids as hypnosis and crystal-gazing.

I need not discuss these modes of treatment in detail, but will proceed to some consideration of the psychoses.

Maniacal-depressive insanity is a disorder in which the patient is liable to attacks of mania, melancholia or stupor, these being in some cases accompanied with, or replaced by, some delusional state.

As I have already stated, it is useless to attack this psychosis

while the patient is passing through one of these acute phases of the disorder. Radical treatment of the disease must be undertaken during a period of sanity or, as the populace would say, during a "lucid interval". It is interesting, moreover, that psycho-analysts, who have had experience of these cases, have come to the conclusion that a very short analysis is most successful in effecting a cure, while a complete analysis, in the Freudian sense, only leads to relapse; but, as I said before, many psycho-analysts of experience differ from me on this point.

A case of my own will serve as an example. She was married in 1910 at the age of 37. In January 1911 she began to lose flesh, suffered from amenorrhœa, which continued until the beginning of April, when she gradually became more and more excited, and remained in a state of acute mania from which she recovered at the end of July. Exactly the same series of events took place in 1912 and 1913. In January 1914 she again began to lose weight. She consulted me and I analysed her for not more than an hour and a half, during which time I discovered a couple of repressed complexes. She afterwards improved in health, had no attack last year, and this year she is doing her ordinary work with no signs of failing health. I regret that I can give no further details, partly because time will not permit, but also for the stronger reason that the patient might be recognised. I can say, however, that the repressed complexes were not of infantile origin.

Dementia præcox has been most carefully studied by Jung from a psychological point of view and the conclusion at which he arrives is that there is a remarkable psychological resemblance between dementia præcox and hysteria. The complexes and the mechanism of their repression are exactly the same, yet hysteria is an eminently curable disease, while dementia præcox is conspicuously incurable. The catatonic symptoms can easily be conceived as purely repressive devices and it has been definitely proved in some cases that certain stereotyped actions are distorted representations of the fulfilment of repressed wishes; but at the same time we must not lose sight of the fact that these same symptoms also occur in certain organic cerebral diseases, whose origin is at least much more organic than psychical. Again, the question is not yet absolutely settled whether dementia præcox is a psychogenic or organic disease. Alzheimer and others have described

areas of gliosis in the deepest layers of the cortex, others have discovered fatty degeneration of the nerve cells, others again have observed cerebellar changes, all of which might very well be due to excess or defect of certain internal secretions.

This idea, surmised by Kraepelin, has been rendered probable by Mott's discovery that certain glands possessing internal secretions, especially the ovaries and testes, are more or less atrophied in dementia præcox. On the other hand, Jung appears to have cured or, at least, considerably ameliorated some cases of dementia paranoides by psycho-analysis only.

Jung recognises all these difficulties and gets out of them by supposing that the mental conflicts of dementia præcox give rise to toxins which act deleteriously upon the cerebral substance. I must confess that to me this idea does not appeal very strongly; but Kraepelin, who will have nothing to do with psycho-analysis, is curiously enough rather pleased with the suggestion.

The chief characteristic of patients suffering from dementia præcox is that they are living a dream and, in the end, completely retire from the world of reality (autism). Up to the present very little psychological investigation of the disease has been made; but we hope to learn much from the investigation now going on at Zurich. For the present, therefore, we must regard the pathology of dementia præcox as still undetermined. By various psychological means, especially by resynthesis, attempts are made to re-form the mental structure of these patients in the early stages; but hitherto the results have not been encouraging.

The last disease I must submit for your consideration is *Paranoia*. This is a mental disorder of the fourth or fifth decade as a rule and it is characterised by the progressive development of systematised delusions. The patients, being of a suspicious temperament, see hidden meanings in incidents which possess no unusual value for the ordinary man and from the inevitable accumulation of such misinterpretations they evolve a system of delusions which vary from patient to patient.

The cases are divided into two main classes:—

(1) The *eccentrics* or *mattoids*, the borderland cases of insanity, including faddists and cranks of all kinds, anarchists, revolutionaries, Christian Scientists, vegetarians, anti-vaccinationists, anti-all-sorts-of-other-things and, in general, people who get a distorted view of life through attaching undue importance to

minor details (this class has not been submitted to modern psychological investigation).

(2) The *egocentrics*, including patients who suffer from delusions of persecution, jealousy, exaltation and ill-health (hypochondriacs). To this class also belong patients who think that some person of the opposite sex makes signs that they are in love with them and also those who believe that they have some religious mission to perform.

All these patients are perfectly clear mentally, have no hallucinations, behave well and can think intelligently apart from their particular delusions; but they are firmly convinced that there is nothing mentally wrong with them and therefore always feel aggrieved when they are involuntarily placed under care for their malady.

Since the advent of our new psychiatry many patients of this class have been analysed by modern psychological methods all over the civilised world and the outcome has been the remarkable discovery that paranoia is a psychosis erected on the invariable basis of repressed homosexuality. Naturally enough the idea that a person has homosexual inclinations is usually repugnant to him, he refuses to admit it to himself and it is repressed into the unconscious. Should such repression fail, the homosexual complex reappears in consciousness in the disguised form of paranoia or, I may add, as dementia paranoides, for it has been shown that the same psychical mechanism is at work in this variety of dementia præcox, designated by Kraepelin in his most recent edition, by the way, as "paraphrenia".

Freud himself has rendered one of these latter cases classical by his analysis of it. Dr David Paul Schreber, a lawyer who was sufficiently eminent to have become President of the Saxon Senate, was under observation from 1893 to 1902 for dementia paranoides. He was released as the result of a legal decision in which the delusions are thus summarised: "He considers himself called to save the world and to bring back the lost state of beatitude. This he could do only by changing himself from a man to a woman". The following year Dr Schreber published a clinical history of his own case, which Freud subsequently analysed with notable psychological insight and showed that the patient was a repressed homosexual.

The researches in paranoia are particularly interesting in that

they throw a certain amount of light on the mechanisms of unconscious reasoning. Unconsciously the paranoiac always starts with the premise, "I love the man" (I am assuming the patient to be a male). The arguments in the several varieties of paranoia then run as follows:—

Persecuted Paranoia.—"I love the man"—an intolerable idea, therefore becoming "I do not love him; I hate him". This by projection becomes "He hates me" "I am persecuted by him".

Exalted Paranoia.—"I love him"—again an intolerable idea, therefore "I do not love him, I love myself". This by projection becomes "Everybody loves me" "I am a great person".

Religious Paranoia.—"I love him", being intolerable, becomes "I love Him" (spelt with a capital H), meaning "I love God". This by projection becomes "God loves me" "I am the chosen one of God".

Amorous Paranoia.—The intolerable "I love him" becomes "I do not love him, I love her". This by projection becomes "She loves me".

Jealous Paranoia.—"I love him", as usual, is replaced by "I do not love him; *she* loves him".

The mechanism of hypochondriacal paranoia is similar to that of exalted paranoia, "I love myself" becoming "I must take care of myself", and querulant paranoia is only a special variety of persecuted paranoia.

Although psycho-analysis has been successful in elucidating the psychology of this disease, the method usually fails as a mode of treatment. I understand, however, that some psycho-analysts have effected a cure and many have alleviated the patient sufficiently to enable him to go about his business with a certain degree of mental comfort without molesting those people with whom he is brought into contact.

Recovery is said to have been effected in a few cases of fairly recent origin by a method which somewhat resembles psycho-analysis, but differs from it in that the physician seeks, in the first instance, to obtain a positive transference before tackling the disease itself. He gets the patient to give a complete history of his life, endeavouring meanwhile to discover incidents and characteristics which have a bearing on his delusional state and to disclose them. During the whole of this process, which takes twenty to thirty hours, he accepts the patient's point of view throughout, until he ultimately gains his whole confidence and

convinces him of his friendship; without, however, actually encouraging his delusions or agreeing with every word he says. Then, when a suitable opportunity offers, he suggests that the patient may have come to an erroneous conclusion about some quite insignificant occurrence. After a few more sittings, as opportunity offers, he points out another minor occasion when the patient might have been mistaken. So he goes on until he sees his chance for tackling the main delusion and pointing out that even here he may also be mistaken. The physician takes advantage of any attitude of doubt and completes the cure by "therapeutic conversation". The whole procedure requires an enormous amount of tact, patience and skill. Moreover, the physician must be familiar with those mechanisms of paranoia which have been discovered by the psycho-analytic method.

The main object of these lectures has been, however, to expound the principles of psycho-analysis proper, its technique, the psychological mechanisms which it has disclosed and the bearing of these mechanisms, not only on 70 per cent. of the 160,000 patients in the asylums of Great Britain, but also in an enormous number of people pursuing their ordinary vocations, in spite of curable mental worries, or spending an enormous proportion of their time and income in nursing homes. Physicians who will undertake the radical cure of these poor sufferers will earn the gratitude of society as well as that of the patients, which is always unbounded; but he must be a man of courage, for he will have to face the opposition of the "herd" for many years to come. In spite of all we may say, the subject of sex will remain taboo, yet no physician of experience can deny the enormous rôle played by sexual conflicts in the genesis of the neuroses. I do think that cases sometimes occur in which the psycho-genetic conflict is non-sexual, but they are so rare that I can see the psycho-analytic literature of the future augmented by reports of such cases as curiosities.

Although I attach so much importance to psycho-analysis, I hope that no words of mine will detract from the systematic investigation of cases by other methods. It would be deplorable, for instance, if attention to psychological investigation should detract from the work of the clinical laboratory and thus allow a positive Wassermann reaction, so common in dementia præcox for example, to be overlooked.

It has often been said that the frequency of mental disease is due to the effect of civilisation, to the hurry, bustle and struggle for existence associated with urban life, to defective sanitation, insufficient sleep, overwork, poverty, brain-fag, education, and a host of other things incident on civilisation. With all our modern conveniences, the poor law, hygienic surroundings, hospitals, comfortable railways with restaurant cars and sleeping accommodation, typewriters and telephones, such a view is manifestly erroneous.

That insanity is the result of civilisation is obvious to anybody who looks the facts in the face; but psycho-analysis has revealed that the essential factor is not hurry, bustle, and brain-fag, but the repression of the instincts, enforced by civilisation. Recognising this fact we can now see the solution of a host of problems in other domains of mental disease. General paralysis, for example, has been ascribed to the effects of civilisation and syphilisation because, although syphilis (an acknowledged factor in the causation of general paralysis) is rife in certain uncivilised communities, general paralysis is rare. The explanation is now forthcoming, for we recognise that the essential difference between civilised and uncivilised communities lies in the fact that the instincts are much more repressed in the former. The recognition of this fact has a practical bearing on both the etiology and treatment of mental disorders.

Our personal impulses tell us to eat, drink and be merry, and to gratify our predatory and sexual instinct, but the herd instinct tells us to be above all such animal passions. The Church, as the highest authority of the herd, says that there must be many days of abstinence and fasting throughout the year in order to subdue the flesh; the Church again and many physicians advocate total abstinence from alcohol; instead of being merry, society dictates that we should be sedate. Our predatory instincts are often stigmatised as cruel, and the openly avowed and ostensible attitude of the populace toward sexual matters is restriction, if possible, to abolition and extinction.

Such limitations imposed by society upon the mighty impulses of the sexual instinct cannot be tolerated with impunity by any normal individual; for a man's sexual activity serves as his standard for all his other activities and, if it is unnaturally repressed, he becomes just as reconciled and submissive in his

whole career; while a person who is so venturesome as to gratify his instincts exhibits the same bold enterprise and energy in overcoming the difficulties of everyday life.

Much less can one who possesses a hereditary predisposition to neurosis or psychosis endure such restraint of his animal instincts, for in such a person it must inevitably lead to mental disorder.

It is not to be supposed that the prophylaxis of insanity lies in letting loose the reins of licentiousness and depravity. The problem is far more intricate than this and it is not likely that it will be solved in the present century, much less in our own time. The mystery at present surrounding sex and birth problems must be removed by systematic education of the young in such matters, early marriage must be made more possible than existing circumstances will permit, and old men and parents will have to remember the days of their own youth when they enact the laws which are to govern society. Moreover, the whole populace will have to be educated in such matters before any serious change can be accomplished.

The idea seems Utopian, and I cannot refrain in this connection from divulging a remark made to me in private conversation many years ago with one of the greatest geniuses that ever lived, Dr Hughlings Jackson. I forget what was the exact topic under discussion, but he said, "I suppose, Stoddart, that the end of the human race will arrive by over-development of the brain at the expense of the testicles". You must remember that he was primarily a neurologist and, as such, a materialist. Translated into psychological language, that remark means "The end of the human race will arrive by the development of culture at the expense of animal passions". Let us hope that such a calamity may be averted

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